

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7001	
BIRTH NO.		65 7001		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Y. (YOUNG) OWENS WILSON (of J)		July 4, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Home: Marlborough Apartments			A. STATE Maryland B. COUNTY 14-07		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) City of Baltimore		
			D. STREET ADDRESS (If rural, give location) Eutaw Place		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 25, 1882	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales-Jan. Supplies		10B. KIND OF BUSINESS OR INDUSTRY Supply House		11. BIRTHPLACE (State or foreign country) Lutherville, Maryland	
13. FATHER'S NAME Joseph Benson Reese Wilson			12. CITIZEN OF WHAT COUNTRY? Maria Eugenia Lloyd		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-05-0442		17. INFORMANT: Wife Mrs. Alice T. Wilson, Marlborough Apts.	
18. 420.12.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Hypertensive Arteriosclerosis Coding Vascular Disease with Coronary Insufficiency</i>			INTERVAL BETWEEN ONSET AND DEATH years.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Benign Tumor of Kidney</i>			1957		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3 July 1965 to 4 July 1965 , that (I) (we) lost saw the deceased alive on 4 July 1965 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lawrence L. Keown</i>			23B. DATE SIGNED 5 July 65		
23C. PHYSICIAN'S NAME (Type) Dr. L. L. Keown			23D. ADDRESS 431 East Lake Ave Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/65		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av.	

Spent time in the
field collecting
specimens.

1957

Spent time in the
field collecting
specimens.

1957

1957

1957

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BIRTH NO. 65 7002		BALTIMORE CITY HEALTH DEPARTMENT		65 7002	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) KELLY, HOWARD A. JR. (Atwood)		2. DATE AND HOUR OF DEATH JULY 5/65 1 8:40 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		A. STATE B. COUNTY MARYLAND Baltimore County			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) LONGBREEN Long green 3-00			
		D. STREET ADDRESS (If rural, give location) Kanes Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/7/1897 1896	9. AGE (In years lost birthday) 68	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. (Retired)		10B. KIND OF BUSINESS OR INDUSTRY RubbersMillers, Inc.		11. BIRTHPLACE (State or foreign country) MARYLAND - Balto.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HOWARD A. KELLY			
14. MOTHER'S MAIDEN NAME Laetitia Bredow		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 217-16-0031		17. INFORMANT : Son ADDRESS Md. A. Preston Kelly, Falls Rd., Butler, Balto. Co.			
18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) METASTATIC CARCINOMA OF PROSTATE (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED UREMIA		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 28 1965 to JULY 6 1965, that (I) (we) last saw the deceased alive on JULY 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Greisman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 5 1965	
23C. PHYSICIAN'S NAME (Type) DR. J. GREISMAN		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Stewart & Mowen Co. 108 W. North Av., City 1			

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7003	
BIRTH NO.		65 7003		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FREDERICK TREBES		2. DATE AND HOUR OF DEATH 7-4-65 1230 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
D. STREET ADDRESS (If rural, give location) 1 W. HENRIETTA STREET					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	B. DATE OF BIRTH 5-24-08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY GENERAL MOTORS		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN TREBES		14. MOTHER'S MAIDEN NAME MARY ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 213 10 4118		17. INFORMANT Mrs. Dorothy Trebes	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		CAUSE OF DEATH (A) DUE TO PNEUMONIA (B) DUE TO CIRRHOSIS OF LIVER (C) _____		INTERVAL BETWEEN ONSET AND DEATH 2 WKS. 1 YR +	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-5-65 to 7-4-65 , that (I) (we) last saw the deceased alive on 7-4-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Coleen C. Heinritz		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-4-65	
23C. PHYSICIAN'S NAME (Type) COLEEN C. HEINRITZ		M.D. ADDRESS SOUTH BALTIMORE GENERAL HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR John E. Fickel	
25C. FUNERAL DIRECTOR JOHN F. DENNY, INC.		ADDRESS 715 Light St.			

BIRTH NO. **65 7004** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 7004**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE E SANFORD				2. DATE AND HOUR PRONOUNCED DEAD July 2, 1965 12:10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4819 Park Heights Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4819 Park Heights Avenue 21215			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan 6, 1907	9. AGE (in years last birthday) 58	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Sanford				14. MOTHER'S MAIDEN NAME Loretta Rogers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Anna Ward as above	
18. E976X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of Head. DUE TO (A) _____ (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4819 Park Heights Avenue			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7 2 '65 A		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Shot self in head.			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/2/65	
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 7/5/65		23C. NAME OF CEMETERY or CREMATORY Provincetown		23D. LOCATION (City, town, or county) (State) Massachusetts, Mass.	
24A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.		24C. FUNERAL DIRECTOR William J. Dickner + Sons North + Adams			

1007 00

1007 00

WALLLEY FORT

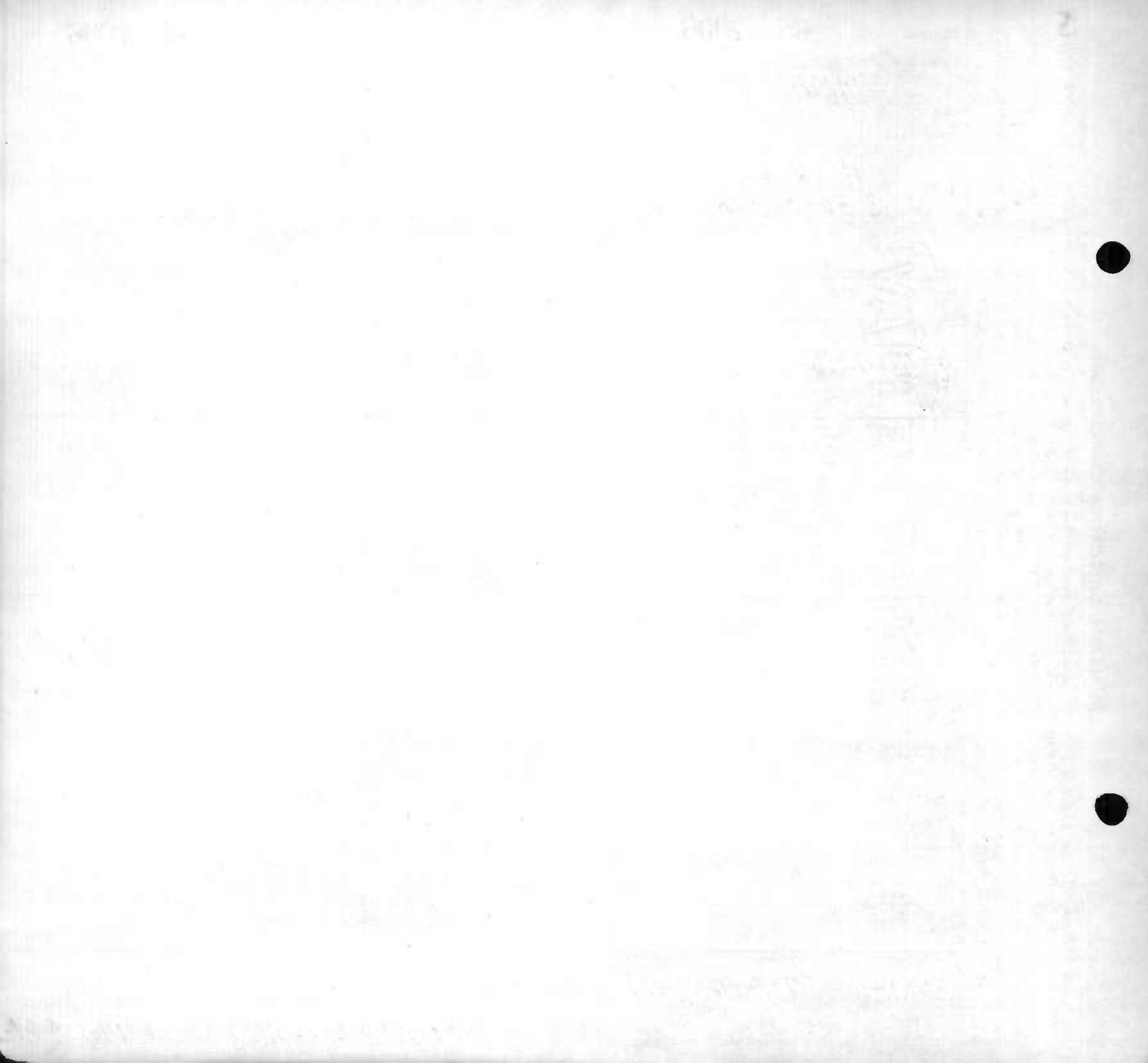
WALLLEY FORT

BIRTH NO. 65 7005		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7005	
M.E. CASE NO.			2. DATE AND HOUR PRONOUNCED DEAD		
1. NAME OF DECEASED (Type or Print) LILLIAN M. BROWN			7-4-65 1:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location)			818 Exeter Hall Avenue 18		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Widowed	Nov. 18, 1904	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Baltimore, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Howard Wilmot			Laura Zilma Hershey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		844 Exeter Hall Ave. Baltimore, Md. 18	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Overdose of Serpasil		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) Cirrhosis of liver		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		818 Exeter Hall Avenue	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
7 4 '65 AM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Ingested overdose of Serpasil - Stabbed self in neck	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		ASSISTANT MEDICAL EXAMINER		7-5-65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		7/7/1965		Loudon Park Cemetery	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
JUL 6 1965		Wm. J. Dubner & Sons		Baltimore, Md. 21217	

FUNERAL DIRECTOR: IMPORTANT

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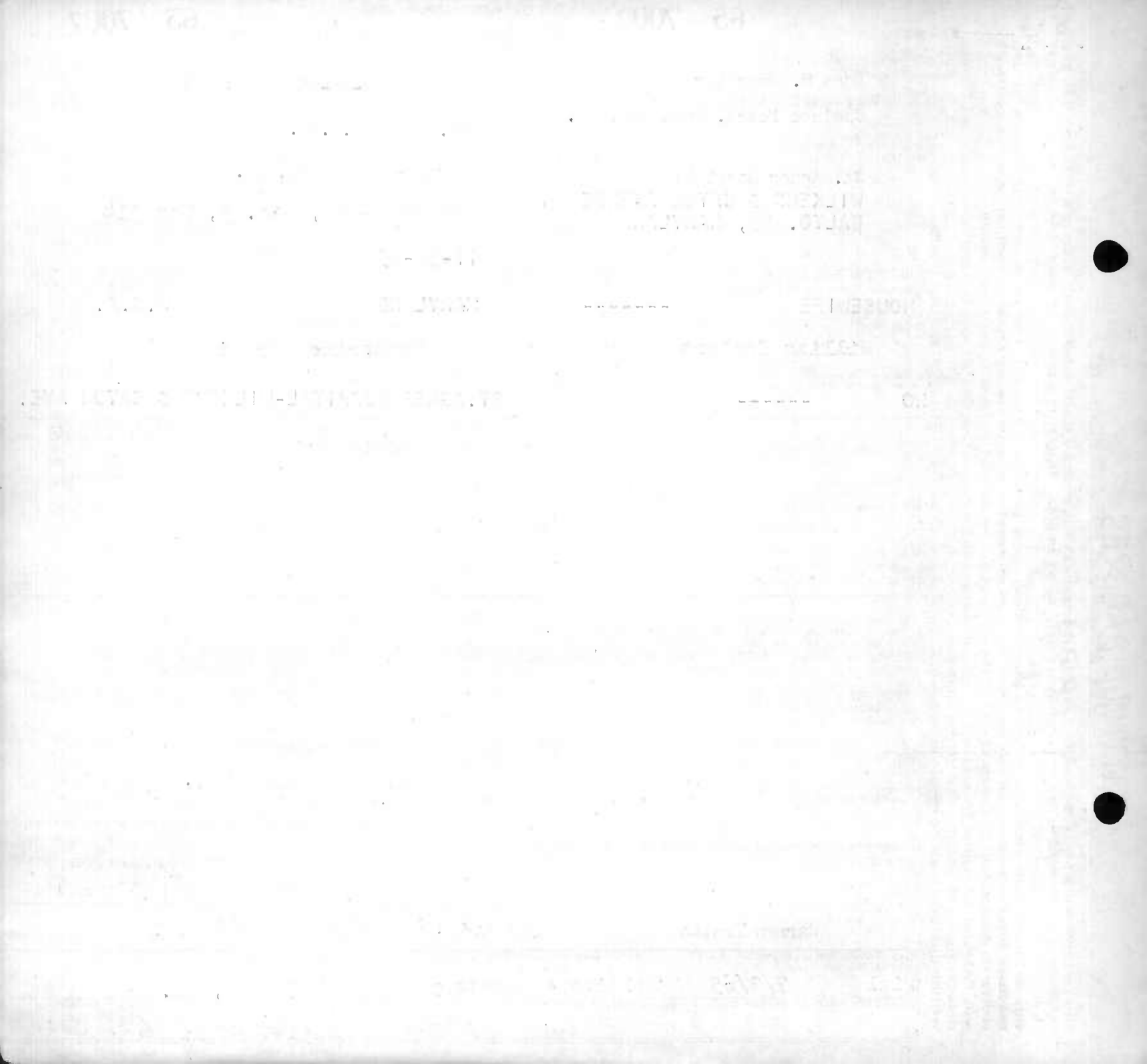
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7006	
BIRTH NO. 65 7006		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EMMA T. COALE		2. DATE AND HOUR OF DEATH JULY 4 1965 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 28-04			
FULL NAME OF HOSPITAL OR INSTITUTION 90 HOOD CONVALESCENT 5313 EDMONDSON AVE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 5313 EDMONDSON AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-2-1907	9. AGE (In years last birthday) 58	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME BERNHARD RODLER		14. MOTHER'S MAIDEN NAME ANNA KRIKEL		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOAN KLOSEK RT#1 KERGER RD	
18. 345X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Multiple Sclerosis DUE TO (B) Progressive Failure DUE TO (C) 4 days		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1 1957 to July 4 1965 , that (I) (we) last saw the deceased alive on July 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Estowes M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7-6-65	
23C. PHYSICIAN'S NAME (Type) James Estowes		23D. ADDRESS M.D. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-7-1965		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

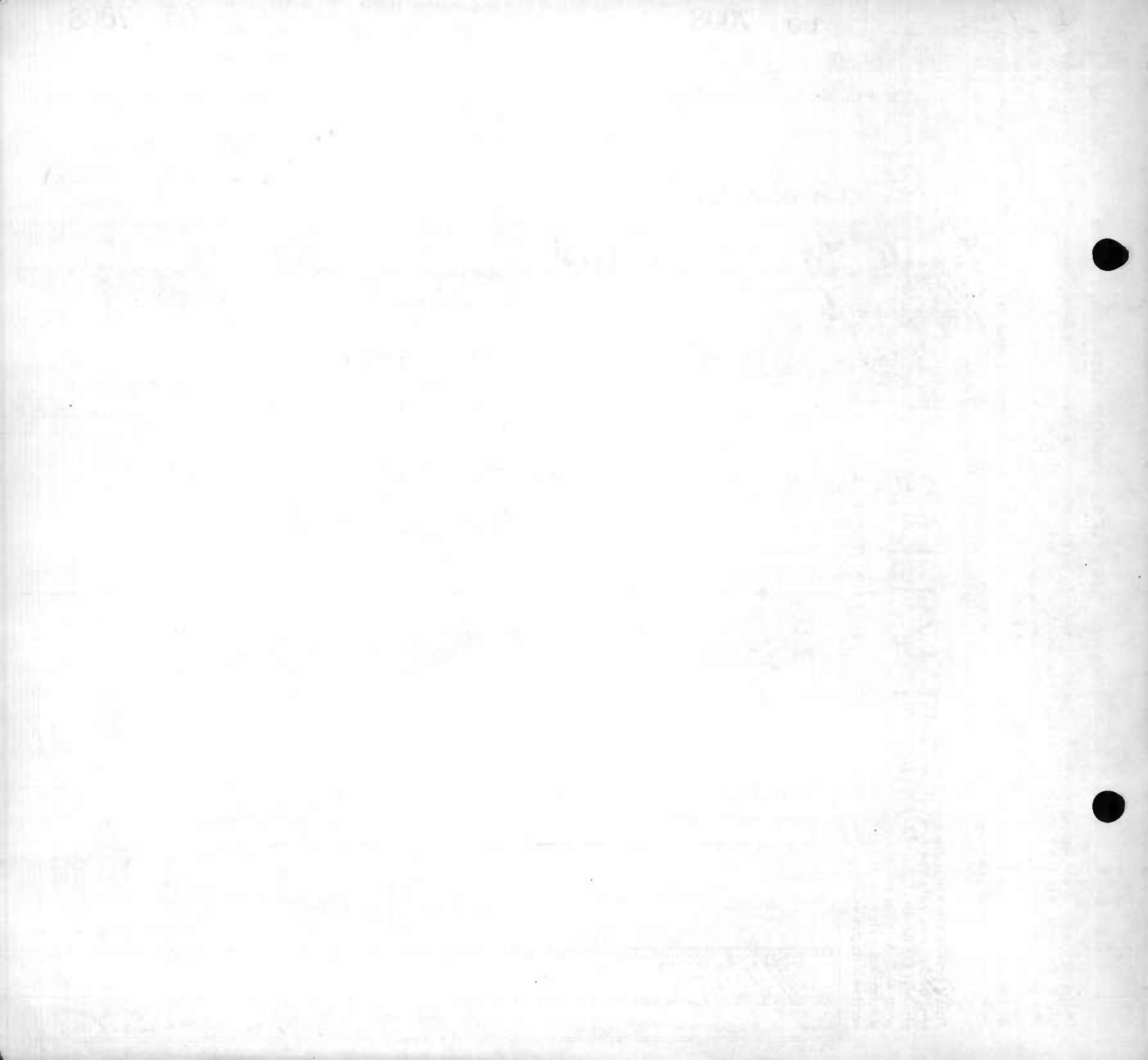
BIRTH NO. 65 7007				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7007			
1. NAME OF DECEASED (Type or Print) Edna M. Spangler								2. DATE AND HOUR OF DEATH 6-30-65 4:45 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Chelsea Beach, Pasadena, Md.								4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY A.A.Co.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital WILKENS & CATON AVENUE BALTO. 29, MARYLAND								C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Pasadena, Md. 52-00			
D. STREET ADDRESS (If rural, give location) Chelsea Beach, Rte. 5, Box 314											
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 11-30-95		9. AGE (In years lost birthday) 69		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Inglart								14. MOTHER'S MAIDEN NAME Katherine Grant			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS ST.AGNES HOSPITAL-WILKENS & CATON AVE.					
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								CAUSE OF DEATH Acute myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
								(A) DUE TO			
								(B) DUE TO			
(C) DUE TO											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/30/65 to 6/30/65 , that (I) (we) lost saw the deceased alive on 6/30/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE Carmen Fratto								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/30/65	
23C. PHYSICIAN'S NAME (Type) Carmen Fratto								23D. ADDRESS St Agnes Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/3/65		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965				25B. NAME OF REGISTRAR Robert E. Fairbank				25C. FUNERAL DIRECTOR ADDRESS KIRKES FUNERAL HOME Glen Burnie			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

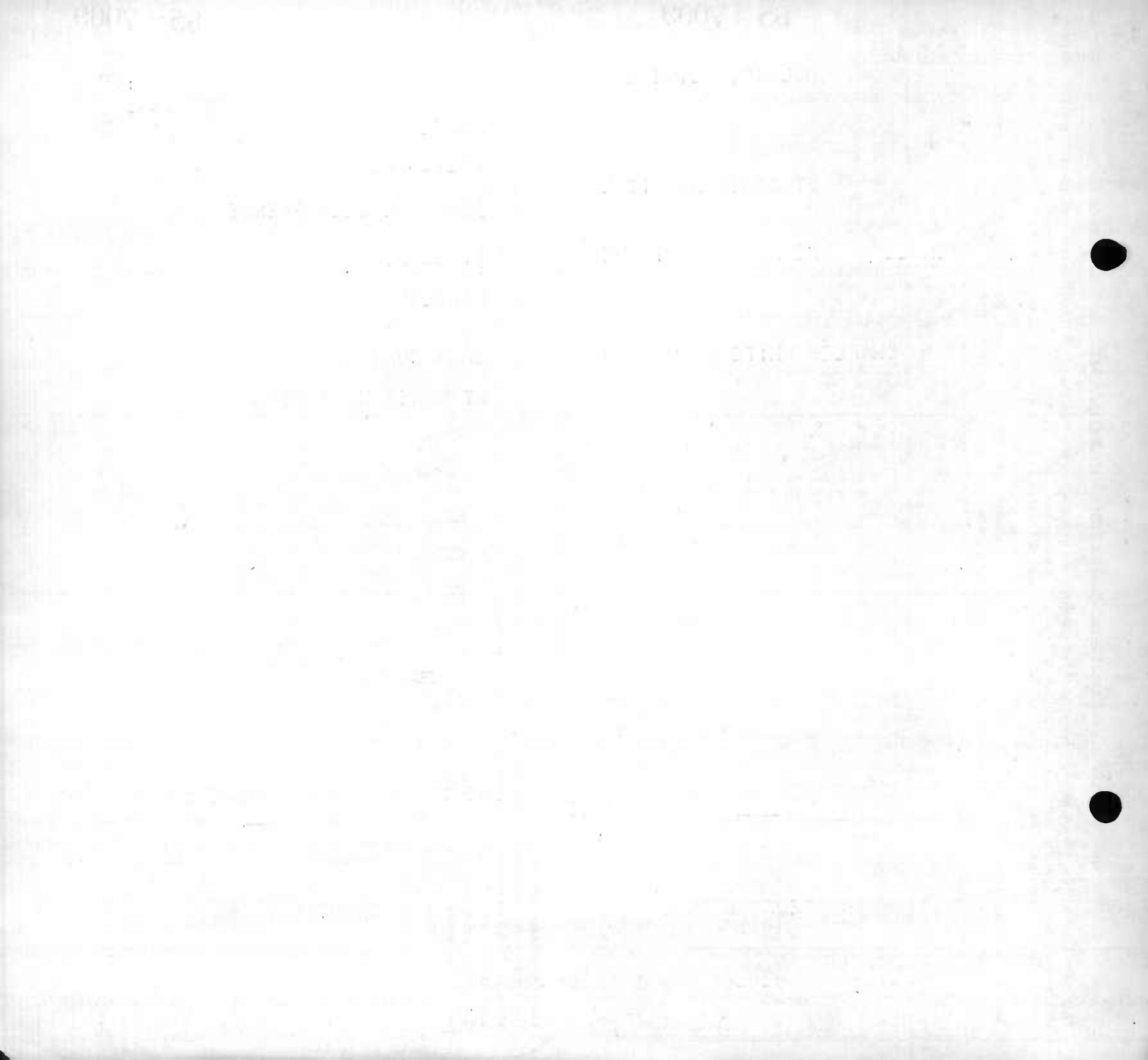
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 7008					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 7008				
1. NAME OF DECEASED (Type or Print) <i>Romm, Rebecca Ann</i>					2. DATE AND HOUR OF DEATH <i>7/2/65</i> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Gertrude Home</i>					A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-17</i>				
D. STREET ADDRESS (If rural, give location)									
5. SEX <i>Female</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH		9. AGE (In years, last birthday) <i>83</i>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Louis Romm</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>					16. SOCIAL SECURITY NO. <i>19-00-3573-02</i>		17. INFORMANT <i>Mrs. Lillian R. Romm</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>446X + 260X</i>					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) <i>Promie Syndrome</i> DUE TO				
ANTECEDENT CAUSES					(B) <i>Chronic Renal Disease (Hypertension)</i> DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) <i>—</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Generalized Arteriosclerosis and Diabetes Mellitus</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>June 15</i> 19 <i>59</i> to <i>July 2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Stanley J. Evans</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>7-2-65</i>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/4/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Beth Hamabrook Hagedool</i>		24D. LOCATION (City, town, or county) (State) <i>Rosedale Balta Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Jack Lewis Inc.</i>		ADDRESS <i>2100 Easton Pl.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

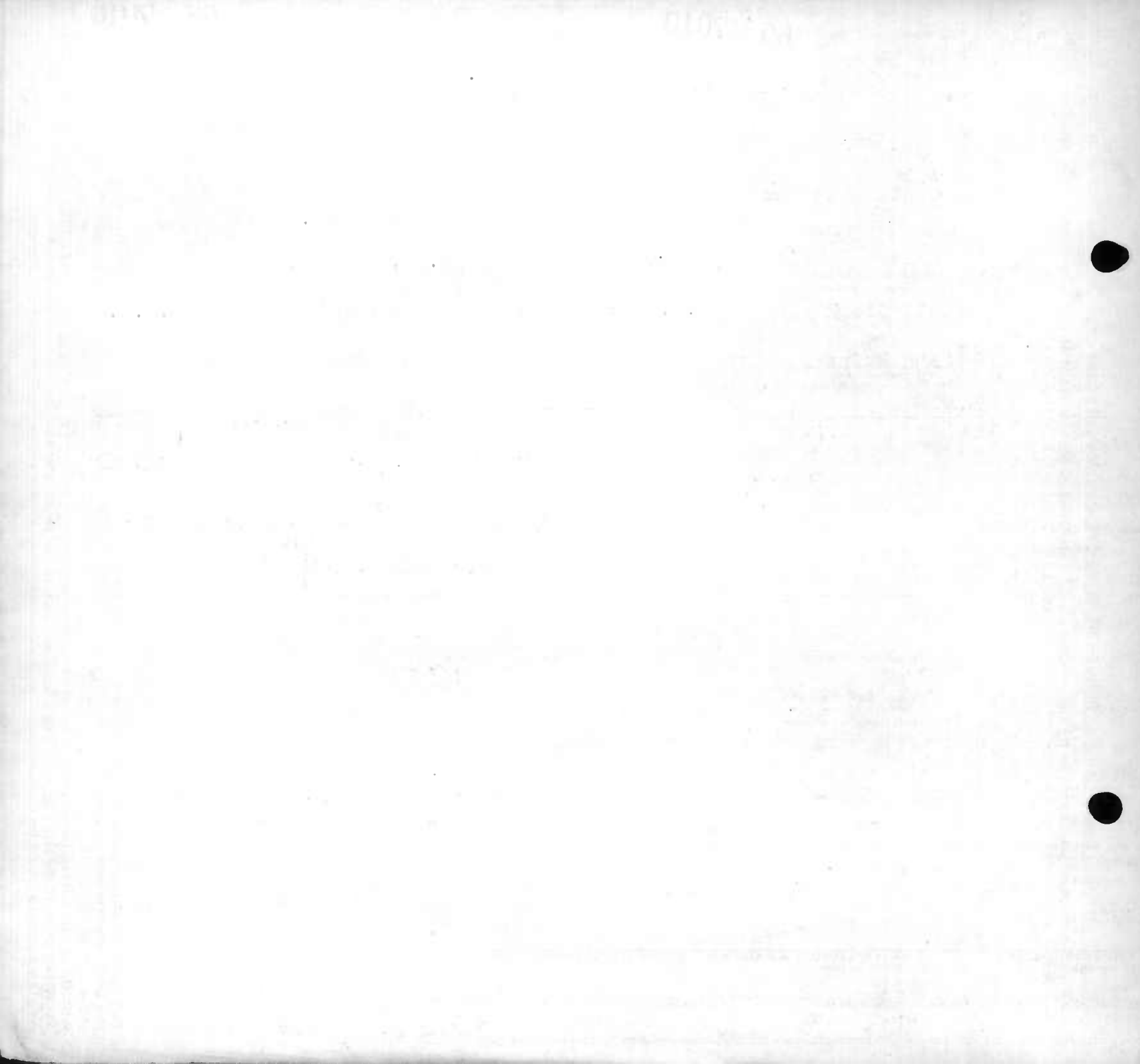
BIRTH NO. 65 7009				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7009	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOLMES, ALICE E				2. DATE AND HOUR OF DEATH 6 30 65 1:00 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 28-41	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15			
				D. STREET ADDRESS (If rural, give location) 3966 DOLFIELD AVENUE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11 22 99	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHARLES WHITE				14. MOTHER'S MAIDEN NAME EMMA JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ST AGNES HOSP RECORDS		ADDRESS	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH C.V.A.-		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 17 1965 to JUNE 30 1965, that (I) (we) last saw the deceased alive on JUNE 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Pedro F. Bajo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Pedro F. Bajo				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-65		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Sarah R. Brown		25D. ADDRESS 125 W. Montgomery	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7010	
BIRTH NO. 65 7010		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE W. RICKMAN		2. DATE AND HOUR OF DEATH 7-3-65 130PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE Maryland B. COUNTY 25X04			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 849 Herndon Ct. 21225			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH Sept. 15, 1894	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Clerk		10B. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Rufus Rickman		14. MOTHER'S MAIDEN NAME Lueania Crews	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 233-38-9469		17. INFORMANT Violet Rickman	
18. 002.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PNEUMOTHORAX DUE TO (B) CHRONIC PULMONARY DUE TO (C) (TUBERCULOSIS) DISEASE		INTERVAL BETWEEN ONSET AND DEATH 15 24 HOURS 10 YEARS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 7-3 185 to 7-3 1965 , that (I) was lost saw the deceased alive on 7-3 1965 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. M. Kang M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/65		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore		24E. LOCATION Maryland		24F. ADDRESS 8521 Loch Raven Blvd.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR John E. Schaefer	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPH FRANKLIN ~~44~~ LONG

2. DATE AND HOUR PRONOUNCED DEAD

July 2, 1965

10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

610 E. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

610 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Oct. 29, 1910

9. AGE (In years last birthday)

60 55

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Anthony Long

14. MOTHER'S MAIDEN NAME

Ida Mae Yeager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)

Yes

WWII

16. SOCIAL SECURITY NO.

213-09-4370

17. INFORMANT

6616 Bowman Hill Joseph F. Long, Jr. Woodlawn, 7

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease. DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7/6/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION (City, town, or county)

Baltimore Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 6

1965

Robert E. Farley, M.D.

5521 Koch Raven B'l

WALLLEY BOFOS

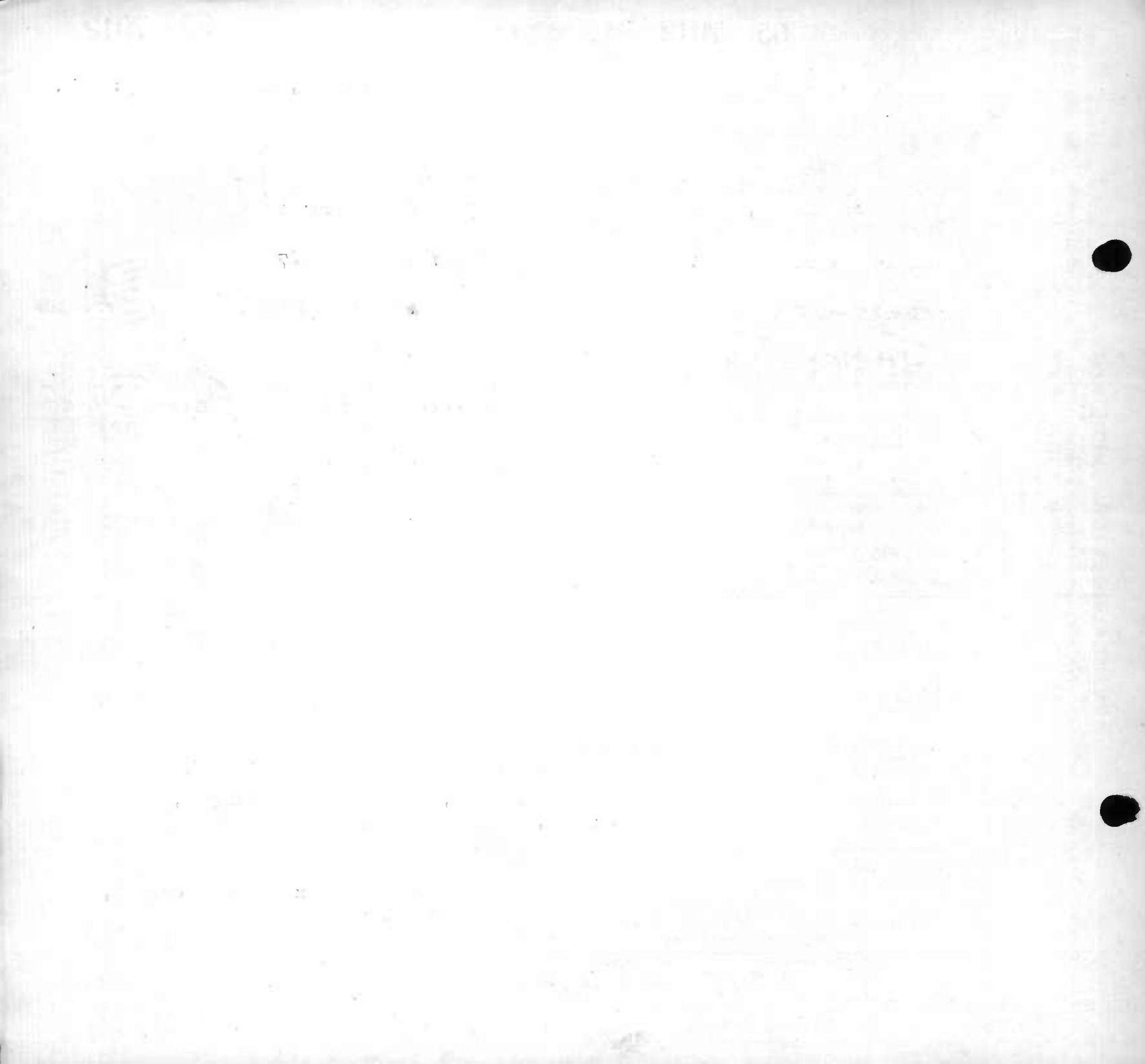
MADE IN GERMANY

1953

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7012	
BIRTH NO. 65 7012		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ozzie Truitt		2. DATE AND HOUR OF DEATH July 3, 1965 3:35 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland		A. STATE Maryland B. COUNTY Baltimore			
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) ?	
8. DATE OF BIRTH Jan. 1, 1908		9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Ba Ho., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Truitt	
14. MOTHER'S MAIDEN NAME UNK.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT G. H. Hill		ADDRESS 626 Smithson ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Left pleural effusion Bronchogenic carcinoma		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3, 1965 19 to July 3, 1965 19, that (I) (we) last saw the deceased alive on July 3, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Theodore		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3, 1965	
23C. PHYSICIAN'S NAME (Type) Roger Theodore		23D. ADDRESS 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-7-65		24C. NAME OF CEMETERY or CREMATORY MT Auburn	
24D. LOCATION (City, town, or county) Ba Ho.		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR McGee & Dyett	
		ADDRESS F. H.			



65 7013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 7013

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Viola Edwards (Giles)

2. DATE AND HOUR OF DEATH

7-1-65

6:50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

917 Wilmer Court - #21217

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

2-10-1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

UNK.

17. INFORMANT

ADDRESS

RECORDS-B.C.H.-4940 Eastern Avenue-#21224

18.

153.8 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.(A) Metastatic Carcinoma
DUE TO

3 months

(B) Colonic Carcinoma
DUE TO

?

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Generalized Arteriosclerosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-25 19 65 to 7-1 19 65,
that (I) (we) last saw the deceased alive on 7-1 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys.Med.
DirectorStaff
Phys. ☒

23B. DATE SIGNED

7-1-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

B.C.H.-4940 Eastern Avenue - Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-6-65

24C. NAME OF CEMETERY or CREMATORY

Arbutus

24D. LOCATION (City, town, or county) (State)

Arbutus

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 6

25B. NAME OF REGISTRAR

Robert E. Tarkenton

25C. FUNERAL DIRECTOR

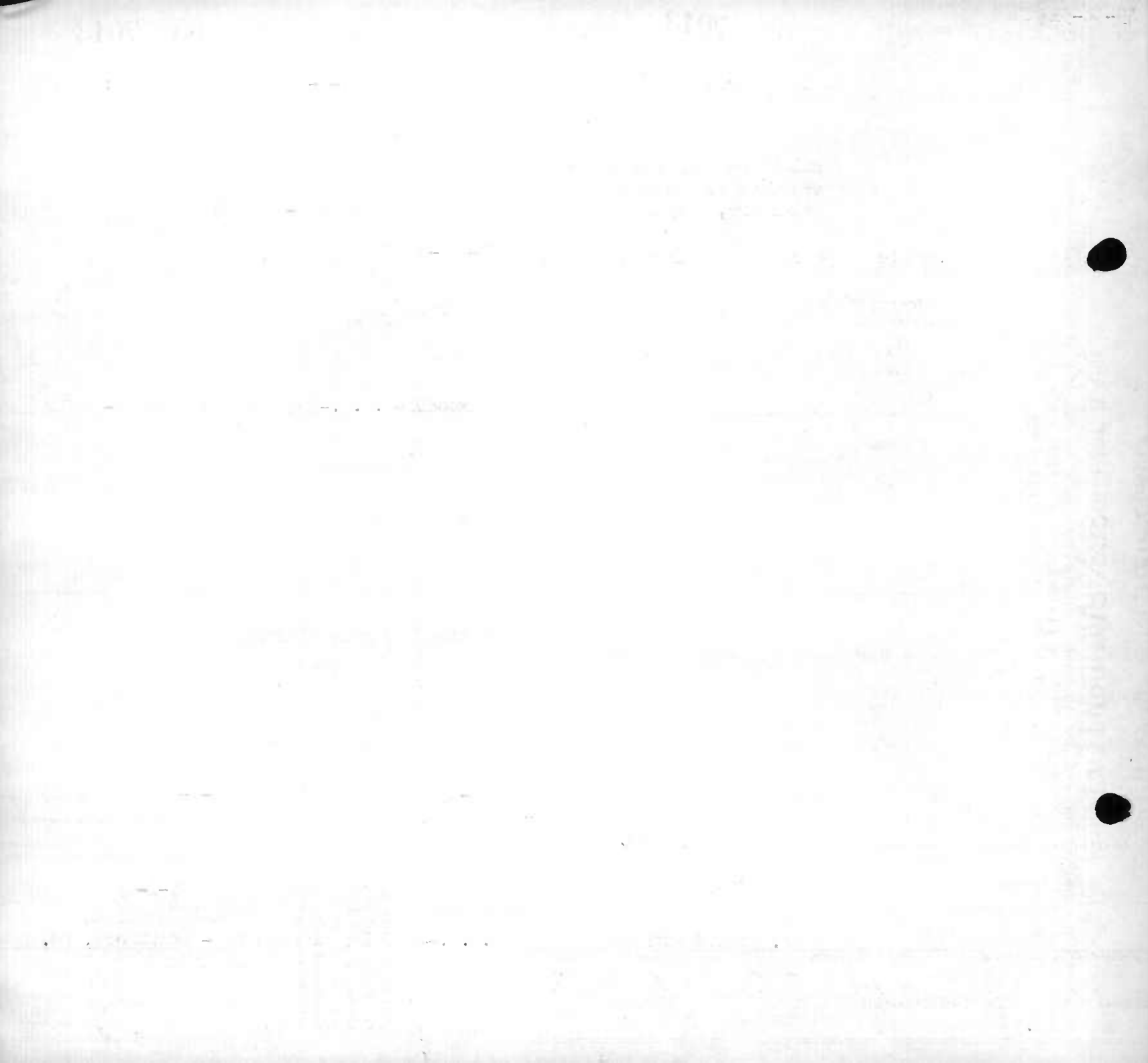
Morton J. Dye

ADDRESS

1701 LAWRENCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

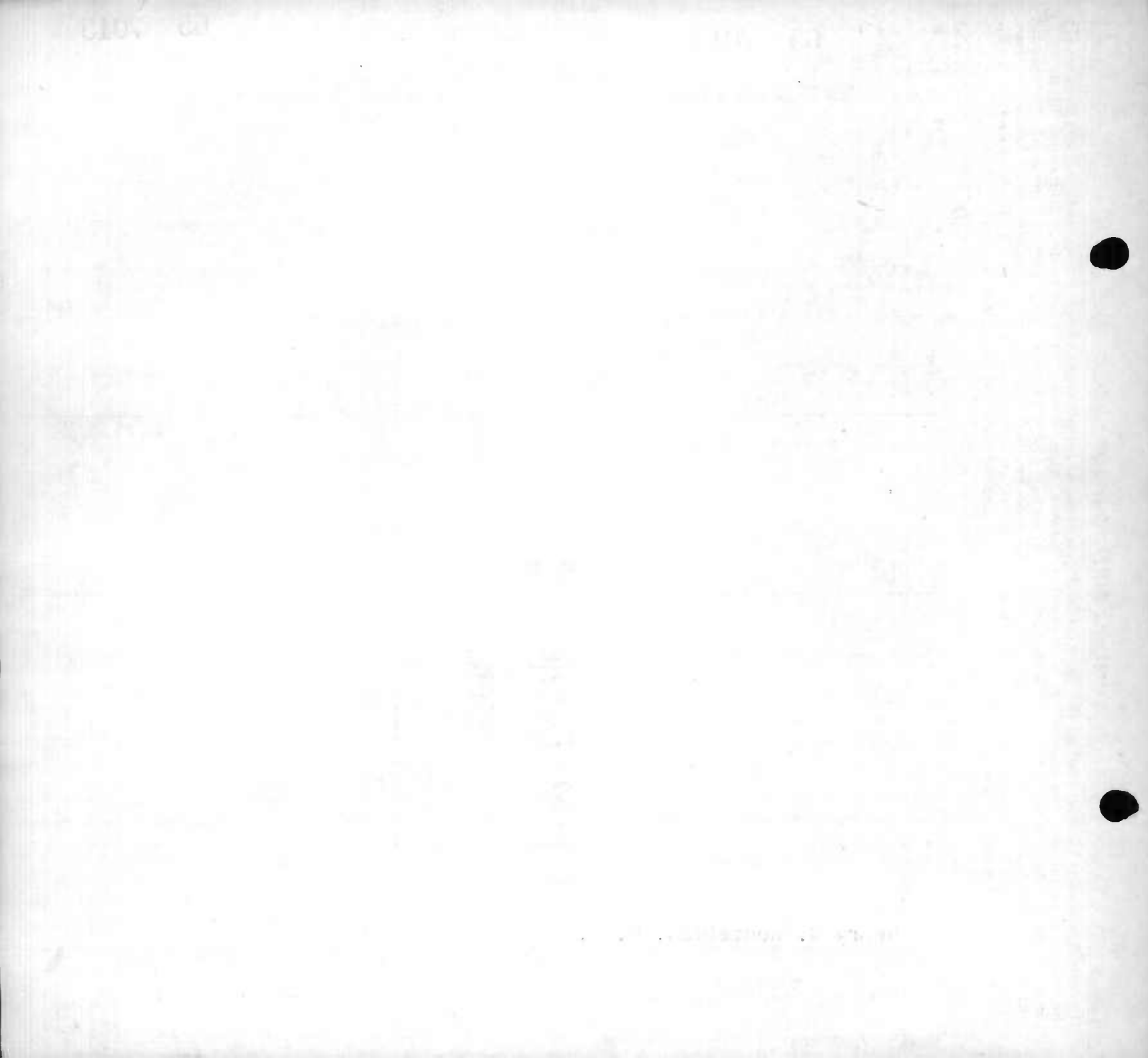
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										65 7014	
CERTIFICATE OF DEATH										Registered No.	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HENRY A. JACKSON				2. DATE AND HOUR OF DEATH July 5 - 1965 4:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Convalescent Home						A. STATE Md. B. COUNTY Charles					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pisgah					
						D. STREET ADDRESS (If rural, give location) 58-00					
5. SEX M		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 12-20-1898		9. AGE (In years last birthday) 66		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK.				10B. KIND OF BUSINESS OR INDUSTRY UNK.		11. BIRTHPLACE (State or foreign country) UNK.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK.						14. MOTHER'S MAIDEN NAME UNK.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Ed. Coby				ADDRESS Pisgah, Md.	
18. 1533 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) adeno carcinoma of sigmoid with liver metastases						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 01-23-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED adeno carcinoma				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 30 1965 to July 5 1965 , that (I) (we) last saw the deceased alive on July 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature]						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7-5-65	
23C. PHYSICIAN'S NAME (Print) [Signature]						23D. ADDRESS 403 Med Art 109					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-65		24C. NAME of CEMETERY or CREMATORY Charles G.				24D. LOCATION (City, town, or county) (State) Charles G. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965				25B. NAME OF REGISTRAR Robert E. Fairbank				25C. FUNERAL DIRECTOR Morton & Dye T. F. H.			
				ADDRESS 1701 LAURENS ST							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

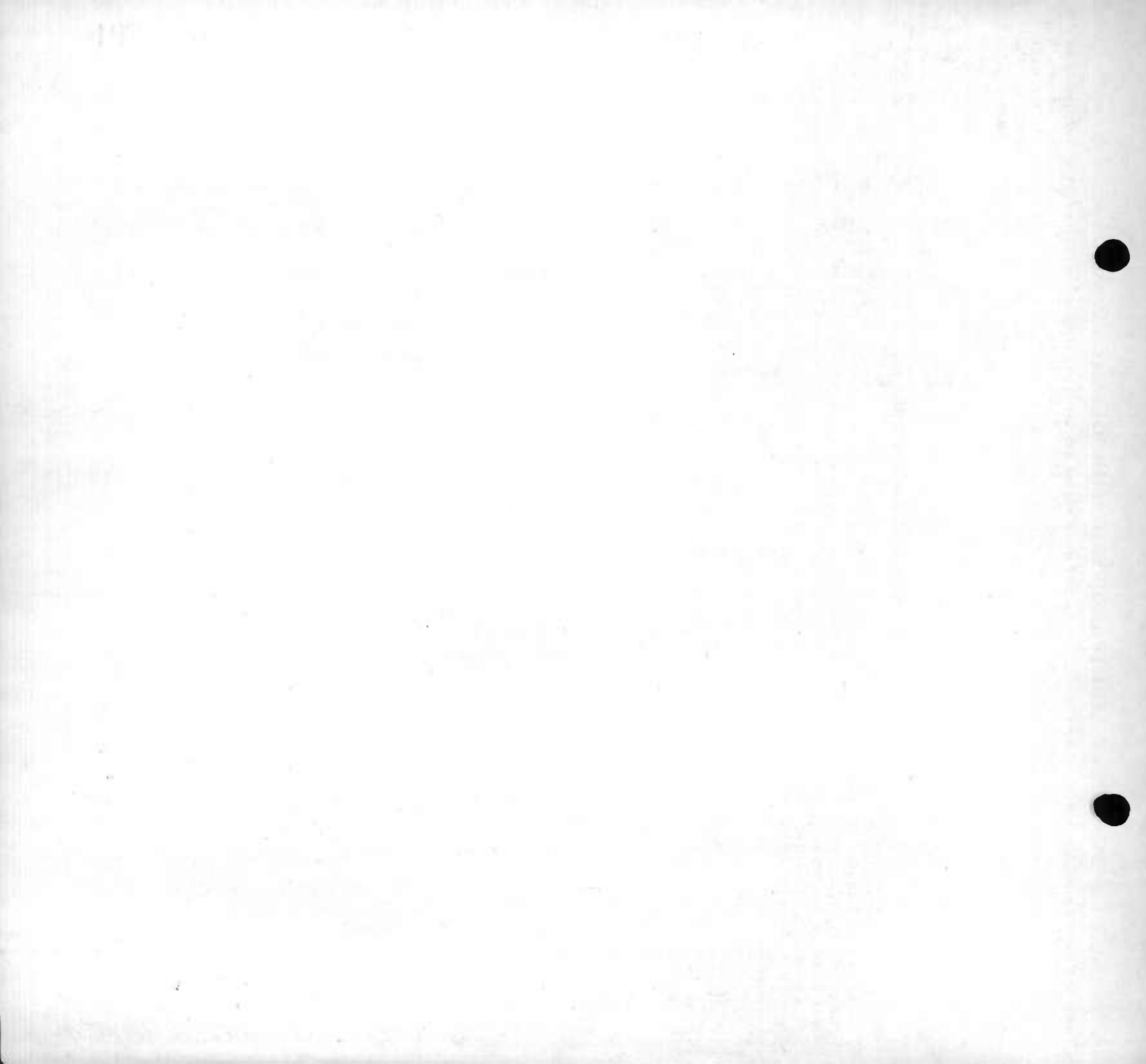
BIRTH NO. 62-05440 65 7015				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 631-7015/8	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Valerie Brown				2. DATE AND HOUR OF DEATH 7/1/65 12 55 a. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Ind. D. STREET ADDRESS (If rural, give location) 2431 Doran Court			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) child	8. DATE OF BIRTH March 3, 1962	9. AGE (In years last birthday) 3 yrs.	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) City Hosp., Baltimore		12. CITIZEN OF WHAT COUNTRY? Baltimore Ind.	
13. FATHER'S NAME William Baker				14. MOTHER'S MAIDEN NAME Annie Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war, or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT William Baker		ADDRESS	
18. 355X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CNS Damage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) CNS Damage DUE TO (B) Infection or Trauma DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days 7-10 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (4) (this hospital) attended the deceased from 6/24 1965 to 7/1 1965 , that (I) (we) last saw the deceased alive on 7/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry J. Konzelman				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/1/65	
23C. PHYSICIAN'S NAME (Type) Henry J. Konzelman, M. D.				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burn		24B. DATE 7/6/1965		24C. NAME of CEMETERY or CREMATORY Mt Calvary Court		24D. LOCATION (City, town, or county) (State) Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Elroy G. Wilson - 1000 Bryant Ave		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

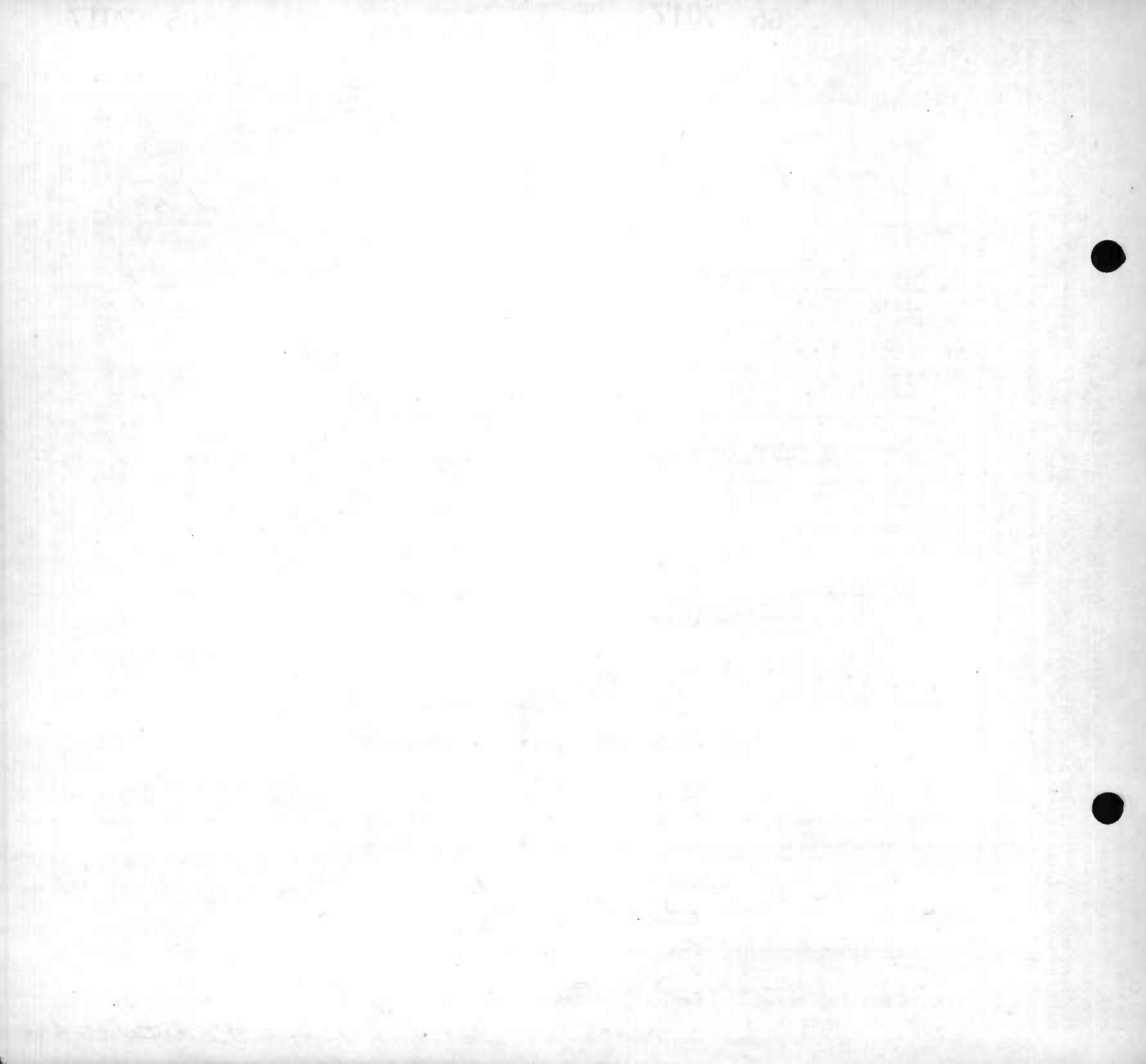
BIRTH NO. 65 7016				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7016	
M.E. CASE NO. 65 7016				1. NAME OF DECEASED (Type or Print) CHESLEY, RONEO R.		2. DATE AND HOUR OF DEATH 6-30-65 1:25 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQ. HOSPITAL 36				A. STATE MD 15-06		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3011 W. NORTH AVE.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12-17-1884	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Post Office				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOSEPH CHESLEY		14. MOTHER'S MAIDEN NAME ELLA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT GERALD C. LORSON 5307 N. Calhoun St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162.15-260X				CAUSE OF DEATH (A) BRONCHOGENIC CA.		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO			
ANTECEDENT CAUSES				(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				DIABETIS MELLITUS			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-1 1965 to 6-30 1965, that (I) (we) last saw the deceased alive on 6-30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) RONEO A. FERRER				23D. ADDRESS FRANKLIN SQ. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1965		24C. NAME OF CEMETERY or CREMATORY Arbutus Park		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 1011 Brantly Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7017	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 7017</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) STOKES, MR BERNARD.</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 6-29-65 11.10 P.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL Hospital</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE BALTIMORE - M.D</p> <p>B. COUNTY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 17-04</p> <p>D. STREET ADDRESS (If rural, give location) 2109 Barclay St. Balto Md.</p>		
<p>5. SEX M</p>	<p>6. RACE E</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M</p>	<p>8. DATE OF BIRTH 3-18-23</p>	<p>9. AGE (In years last birthday) 42</p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) VA</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A</p>					
<p>13. FATHER'S NAME ROBERT STOKES</p>			<p>14. MOTHER'S MAIDEN NAME MAUDE LEE</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Mother</p>	
<p>ADDRESS SAME</p>					
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>(A) Bronchogenic Carcinoma</p> <p>(B) MASSIVE hemoptysis</p> <p>(C) CARDIAC ARREST</p> <p>INTERVAL BETWEEN ONSET AND DEATH 1 month</p>					
<p>MEDICAL CERTIFICATION</p> <p>19A. DATE OF OPERATION 16/24/65</p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Lung</p> <p>20A. AUTOPSY? (Yes or No) No</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p> <p>22. I certify that (I) (this hospital) attended the deceased from 6-2 19 65 to 6-29 19 65, that (I) (we) last saw the deceased alive on 6-29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Jamie Ramirez</p> <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>				<p>23B. DATE SIGNED 6-29-65</p>	
<p>23C. PHYSICIAN'S NAME (Type) M.D.</p>				<p>23D. ADDRESS M.D.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7-5-65</p>		<p>24C. NAME OF CEMETERY or CREMATORY Baltimore Nat</p>	
<p>24D. LOCATION (City, town, or county) (State) Baltimore Md</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965</p>		<p>25B. NAME OF REGISTRAR R. E. Fulkerson</p>		<p>25C. FUNERAL DIRECTOR Choy Wilson 1000 Brantly Ave</p>	
<p>ADDRESS</p>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7018	
BIRTH NO. 65 7018		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. Irma Valentine Dixon		2. DATE AND HOUR OF DEATH 6-30-65 12:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md. 14-03			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Montebello S. Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto			
D. STREET ADDRESS (If rural, give location) 1906 McCallist st.					
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 2-14-1911	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME EDWARD ?		14. MOTHER'S MAIDEN NAME ? Haskins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Montebello State Hospital	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Carcinoma of lung with metastases to the cervical spine (B) DUE TO Diabetes mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4-30-65 to 6-30-65, that (I) (we) last saw the deceased alive on 6-30-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Orlando R. Ramos		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-30-65	
23C. PHYSICIAN'S NAME (Type) Orlando R. Ramos		23D. ADDRESS Montebello S. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1965		24C. NAME OF CEMETERY or CREMATORY Calverton	
24D. LOCATION (City, town, or county) Balto Md		24E. (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Chas. O. Wilson - 1000 Brantly Ave	

Mr. J. W. Anderson, Director, Bureau of Land Management, Washington, D. C.

Re: Application for a patent in right of the United States for certain improvements in the method of

conducting a survey of land.

Enclosed for the Bureau are two copies of a report of the Surveyor General of the Territory of

Idaho, dated at Boise, Idaho, this 1st day of March, 1904, and a copy of a letterhead memorandum of the

Surveyor General of the Territory of Idaho, dated at Boise, Idaho, this 1st day of March, 1904, and a copy of a letterhead memorandum of the

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Surveyor General of the Territory of Idaho, dated at Boise, Idaho, this 1st day of March, 1904, and a copy of a letterhead memorandum of the

LS: 43-65-84

65 7019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 7019

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Lila Mae Gee

2. DATE AND HOUR OF DEATH

July 2, 1965

7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3017 Seamon Avenue #21225

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-23-18

9. AGE (In years
last birthday)

47

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Hawkins

14. MOTHER'S MAIDEN NAME

Bessie Johnson

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

220-12-5177

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18.

170 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury at complication which caused death.)(A) Metastatic Carcinoma of Breast
DUE TO

2 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Gastro-Intestinal Bleeding
DUE TO

1 Month

(C) Carcinoma of Breast

2 Years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Transection of Cord

6 Weeks

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 21, 19 65 to July 2, 19 65,
that (I) (we) last saw the deceased alive on July 2, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 2, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/8/65

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

(Street)

Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 6

1965

25B. NAME OF REGISTRAR

Robert E. Fink

25C. FUNERAL DIRECTOR

Washington Phillips

ADDRESS

1727 N. Monmouth St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

James Smith

William Smith

James Smith

2-12-1878

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7020		CERTIFICATE OF DEATH		Registered No. 65 7020	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Mother Green</i>		2. DATE AND HOUR OF DEATH <i>7/4/65</i> <i>12³⁰</i> A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Nursing Home</i>		A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location) <i>2711 Carey St</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore md</i>			
		D. STREET ADDRESS (If rural, give location) <i>1108 Druid Hill ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9/19/85</i>	9. AGE (In years last birthday) <i>79</i>	10. BIRTHPLACE (State or foreign country) <i>West Virginia</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Henry Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Tugman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT ADDRESS <i>Arthur Green 1108 Druid Hill ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>260X15/170X</i>		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Cardiovascular Disease</i>			
ANTECEDENT CAUSES		(B) DUE TO <i>Left High Anomalous</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO <i>Left Heart Failure</i>			
II		INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 9 - 1965</i> to <i>July 4 1965</i> , that (I) (we) last saw the deceased alive on <i>July 1 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>yes</i>					
23A. SIGNATURE <i>W. R. Johnson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>July 4 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. R. Johnson</i>		23D. ADDRESS <i>203 Mel Arls</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>7/6/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>Harpers Ferry W. Virginia</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wilmington S. Phillips 1727 N. Howard St.</i>			

1872 - 2nd year
No 27

Eastern Shore
of Maryland

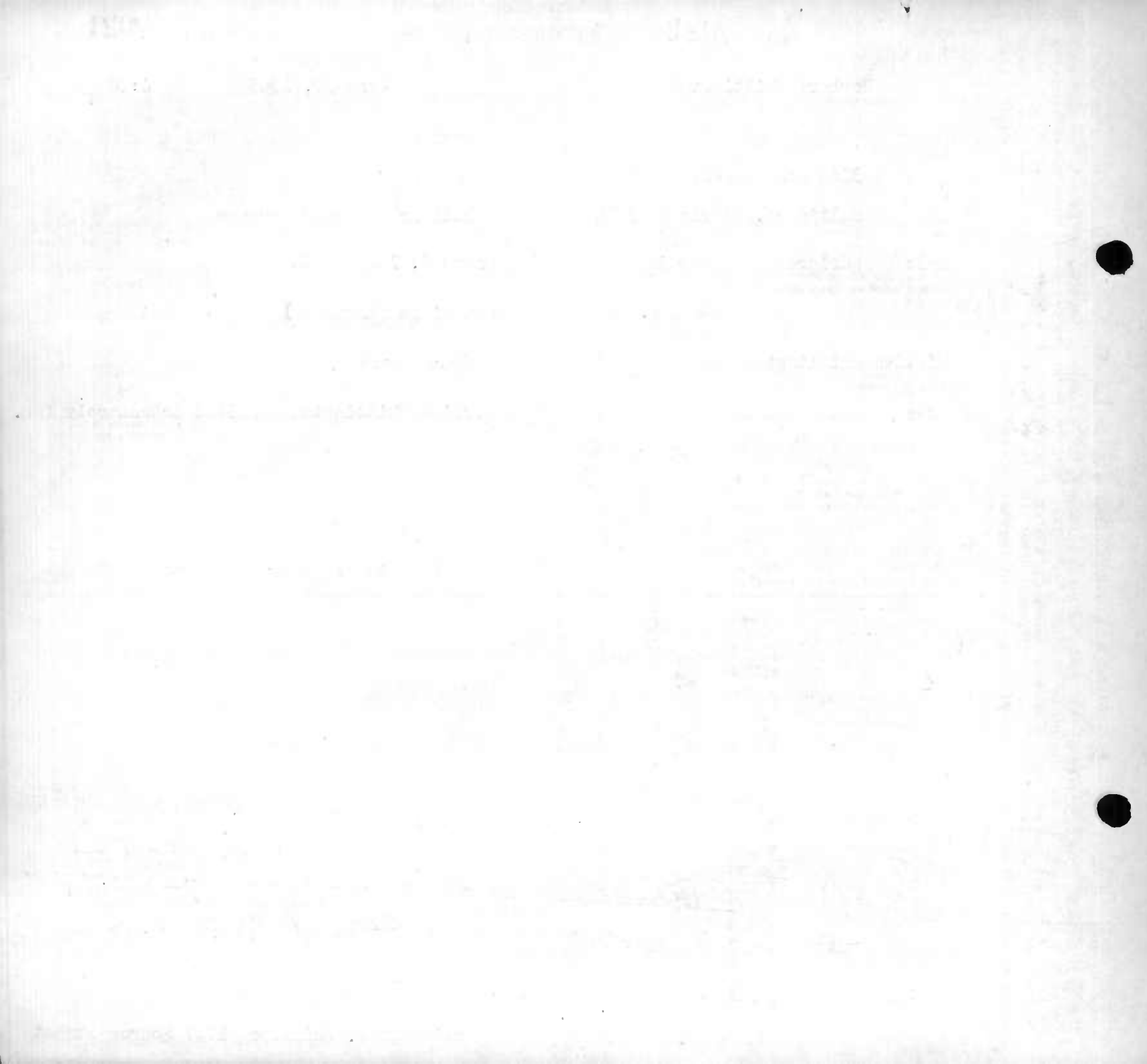
Thompson

Alfred C. Thompson
1872

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7021				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7021		
1. NAME OF DECEASED (Type or Print) Herbert Whittington				2. DATE AND HOUR OF DEATH June 30, 1965 4:40 p.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3446 Achentoroly Terrace Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY USA C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3446 Achentoroly Terrace				
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 5, 1913	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Glen L. Martin	11. BIRTHPLACE (State or foreign country) Cambridge (Maryland)		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Whittington			14. MOTHER'S MAIDEN NAME Barbara Moore					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO.		17. INFORMANT Corrine Whittington ADDRESS 3446 Achentoroly Ter.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis Coronary Infarct Hyper + Hypertension				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 2-18-65				
MEDICAL CERTIFICATION 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1962 to June 30 19 65 , that (I) (we) last saw the deceased alive on June 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Found dead								
23A. SIGNATURE Geo. H. Pendleton M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7-2-65				
23C. PHYSICIAN'S NAME (Type) Geo. H. Pendleton M.D.				23D. ADDRESS 1723 Duin Hill Ave				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/65		24C. NAME OF CEMETERY or CREMATORY Evergreen Cemetery		24D. LOCATION (City, town, or county) (State) Brooklyn New York		
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Arlington S. Phillips			ADDRESS 1727 Monroe Street	



IS: 38-80-671

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 7022		65 7022	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Clarence Dorsey		2. DATE AND HOUR OF DEATH July 4, 1965 7:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Maryland 14-02	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #24		D. STREET ADDRESS (If rural, give location)		642 Mosher Street #21217	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9-25-88	9. AGE (In years last birthday) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-058066		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I 181.1 Coronary Occlusion		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) Arteriosclerotic Cardio Vascular Disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bladder Carcinoma			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 25, 19 65 to July 4, 19 65, that (I) (we) last saw the deceased alive on July 4, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Robert Bridge		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Robert Bridge		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Arlington S. Shell		25D. ADDRESS 1727 N. Monaca			

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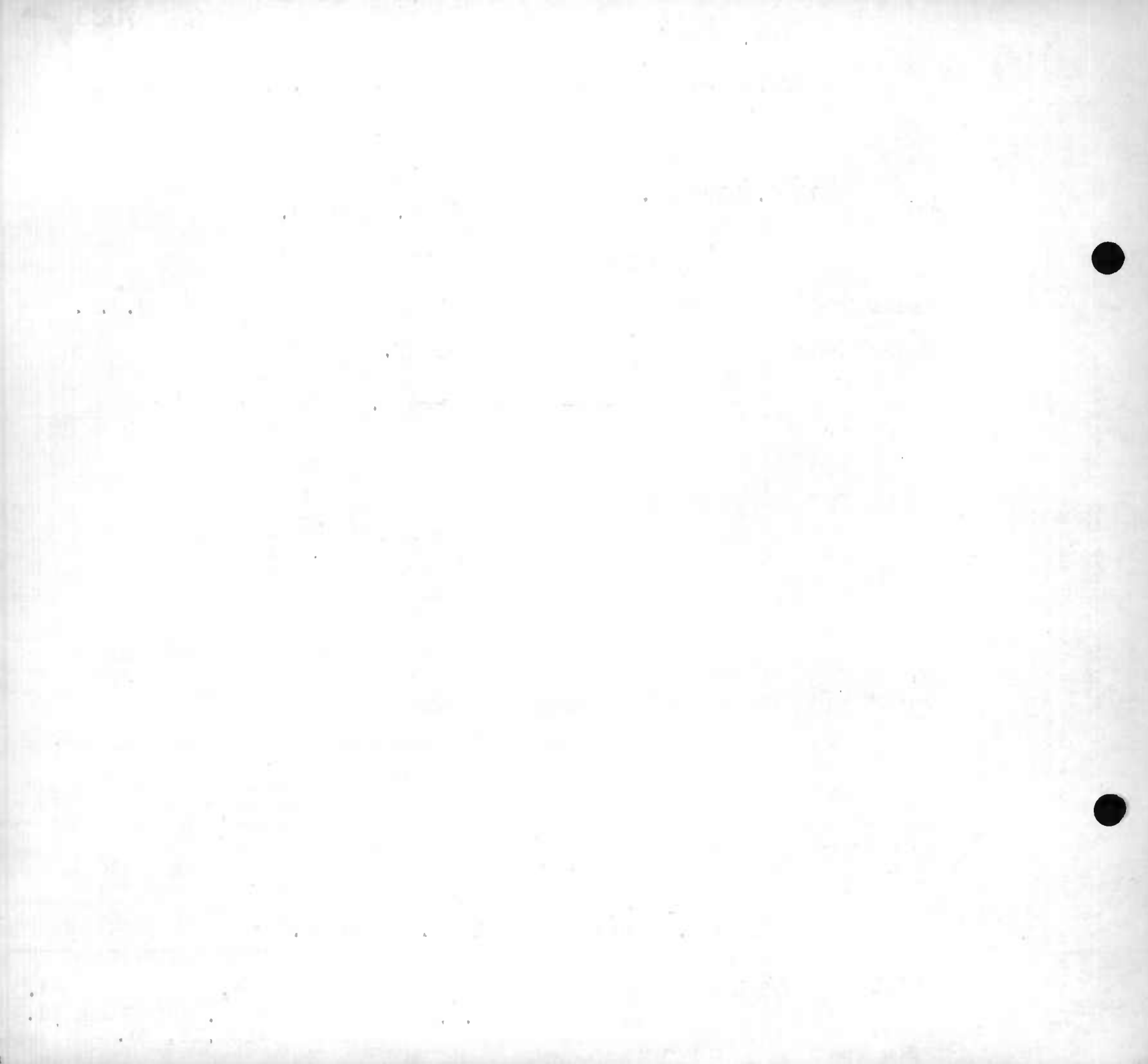
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7023	
BIRTH NO. 65 7023		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Effie Grape Curlander		July 4, 1965 3:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
514 E. 43rd St.		Maryland		27-10	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		514 E. 43rd St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	Married	5/6/1877	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Grape		Laura V. Horney		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220-30-7242B		Edward H. Curlander (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X I		Cerebrovascular Accident			
ANTECEDENT CAUSES		(B) Generalized & Cerebral			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C) Anterior			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1955 to 1965, that (I) (we) last saw the deceased alive on July 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Walter B. Buck				7/6/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Walter B. Buck		18 E. Eager St.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)		(State)
Burial	7/7/1965	Loudon Park	Baltimore,		Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
JUL 6 1965	Robert E. Farber		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		



65 7024

BALTIMORE CITY HEALTH DEPARTMENT

65 7024

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARVEY L. HALL

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1965

11:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

402 E. Lake Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7/5/1900

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

V.P., Trust Director Md. Nat. Bank

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George A. Hall

14. MOTHER'S MAIDEN NAME

Margaret M. Hall

Josephine Dodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-01-5008

17. INFORMANT

Margaret M. Hall

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)1. Congestive heart failure
(A) ~~CHRONIC~~2. Advanced carcinoma of prostate, (Clinical)
(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/6/1965

23C. NAME of CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 6 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.
Baltimore 12, Md.

ADDRESS

1-10-10-8

VALLEY FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY DEPARTMENT		Registered No.	
M.E. CASE NO.				65 7025		65 7025	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Smith, William Francis (Jr.)				July 2, 1965		2:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				Maryland Baltimore			
D. STREET ADDRESS (If rural, give location)				215 Oakdale Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
Male	Caucasian	Married	7/2/95	69			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman-Retired		Unknown		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William, F. Smith, Sr.				Julitte Weeks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 4/13/17 to 5/14/19				213 09 9403		Veterans Hospital Records Baltimore, Maryland 21218	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) C arcinoma Pancreas, with Metastasis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pulmonary Tuberculosis			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from May 25, 19 65 to July 2, 19 65, that (X) (we) lost saw the deceased alive on July 2, 19 65 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John S. Howe M.D.				July 2, 1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John S. Howe				Veterans Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/6/1965		Greenmount		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 6 1965		Robert E. Jenkins		Jenkins Funeral Home, York Rd., Balto., Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 7026		CERTIFICATE OF DEATH X Registered No. 65 7026							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Blanche Serena Gerwig</i>				2. DATE AND HOUR OF DEATH <i>7-3-65 11:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #34 53-00</i> D. STREET ADDRESS (If rural, give location) <i>8004 Hillendale Rd</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/12/1889</i>		9. AGE (In years lost birthday) <i>76</i>		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Samuel Houston</i>				14. MOTHER'S MAIDEN NAME <i>Isabelle Cox</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Evelyn Smith</i>			ADDRESS (Same)		
18. <i>433.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Cerebral Vascular Accident</i> DUE TO (B) <i>Atrial fibrillation</i> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>27 days</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>July 1 19 65</i> to <i>July 3 19 65</i> , that (I) (we) last saw the deceased alive on <i>July 3 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Hudson Fesche</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7-3-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>P. HUDSON FESCHE,</i>		23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1965</i>		25B. NAME OF REGISTRAR <i>R. E. Fesche</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto.</i>			ADDRESS <i>74 Md.</i>		

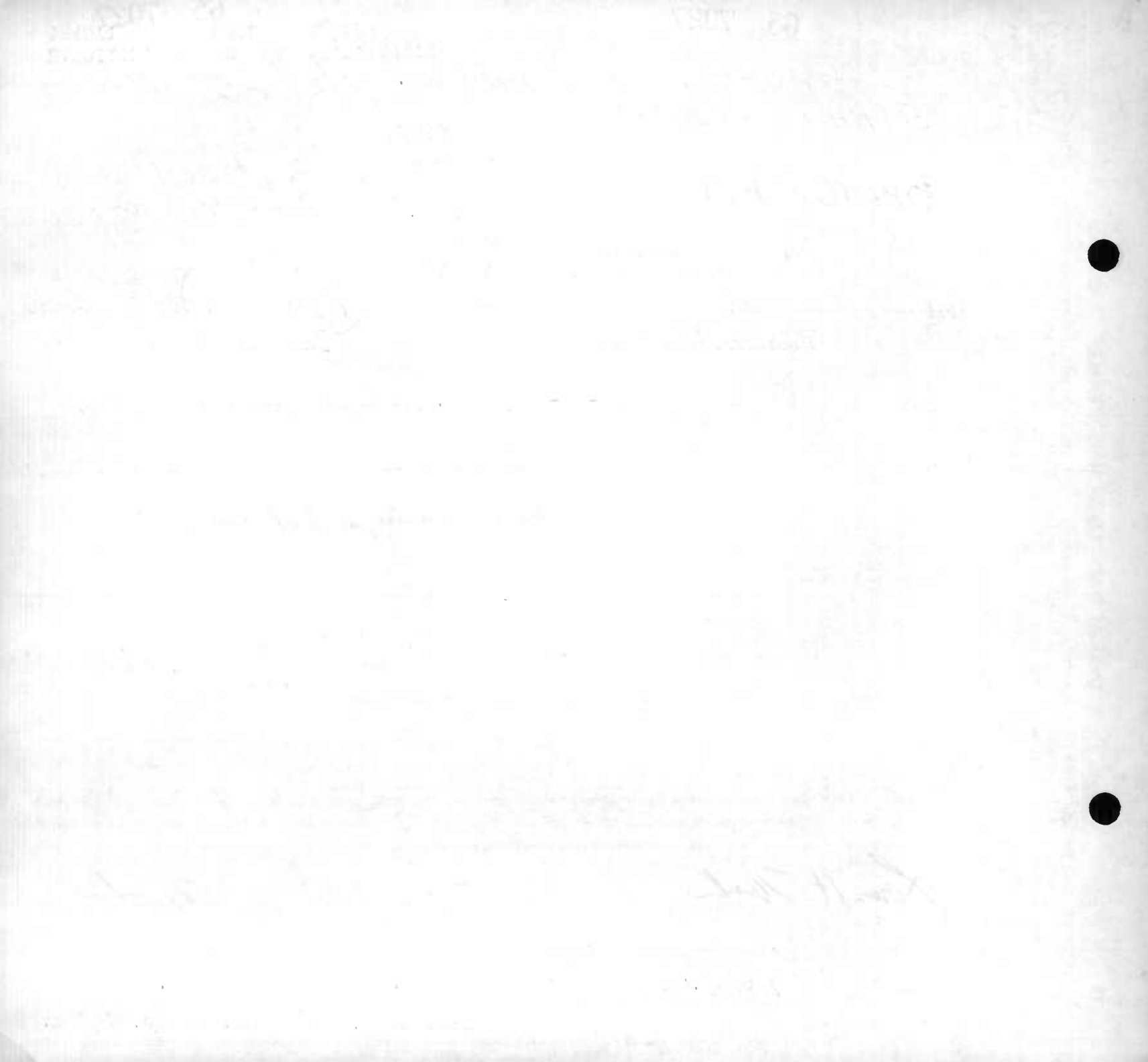
THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

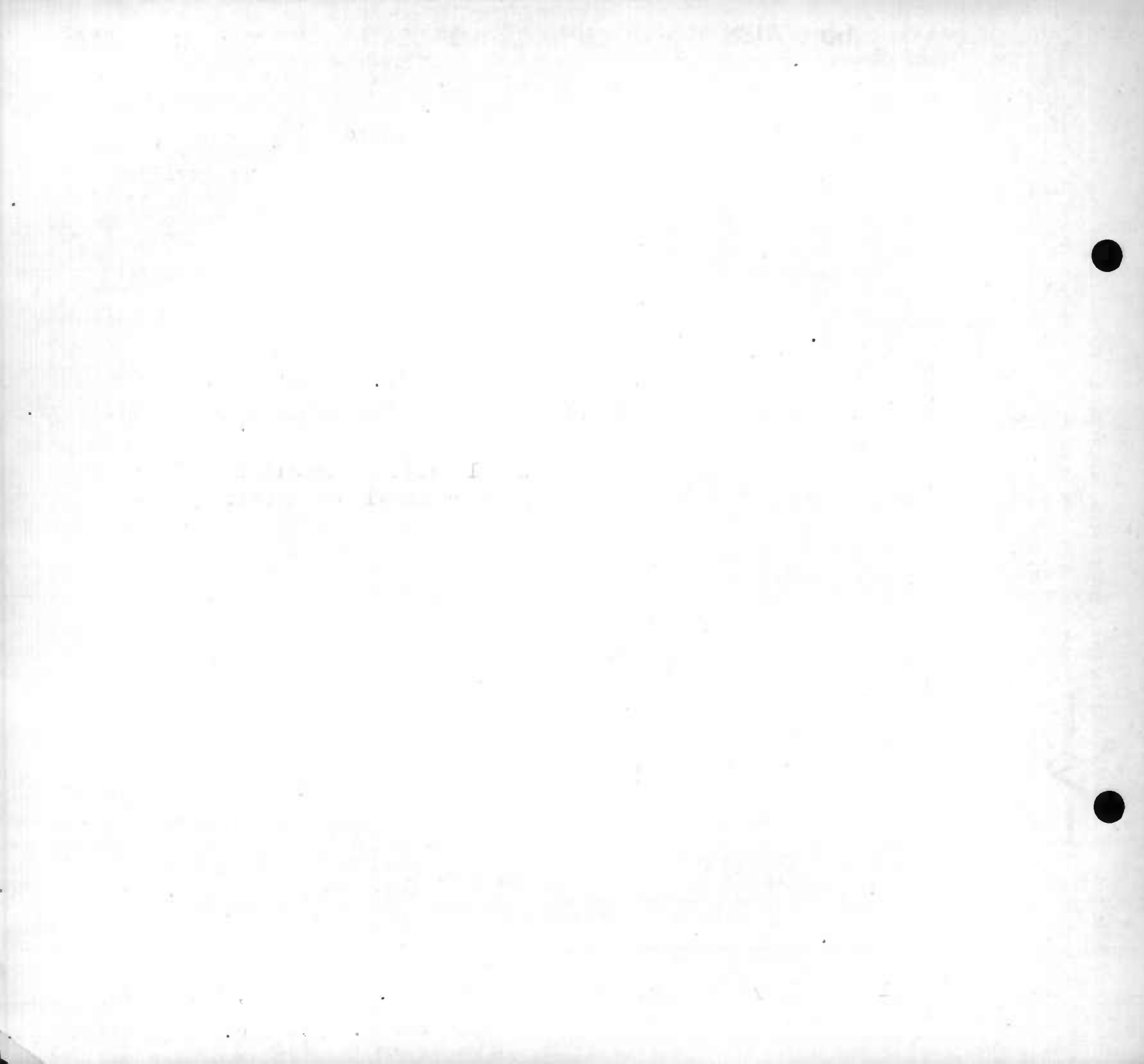
BIRTH NO. 65 7027		BALTIMORE CITY HEALTH DEPARTMENT		Register 1000 65 7027	
M.E. CASE NO.		CERTIFICATE OF DEATH		NIXON, J. H. 85	
1. NAME OF DECEASED (Type or Print)		HARRISON, WILLIAM Jos.		DATE AND HOUR OF DEATH 7/2/65 11:35A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
SINA I HOSPITAL		A. STATE Md.		B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
42 BALTO. Md.		BALTO. 12, Maryland		6307 BEECHWOOD ROAD	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/7/06	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Artist Illustrator			England	(AMERICAN)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Theodore Harrison		Florence Press			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW 2		216-01-4515		Mrs. Gretchen Harrison (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Septicemia		6/29/65-7/2/65	
ANTECEDENT CAUSES		(B) Pyelonephritis, intestinal colic			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	423		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 6-29-1965 to 7-2-1965, that (I) (we) last saw the deceased alive on 7-2-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
James H. Parker		7/2/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	7/6/65	Baltimore National Cem.	Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1965	Robert E. Taylor	Leonard J. Ruck Inc. Balto.		14 Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

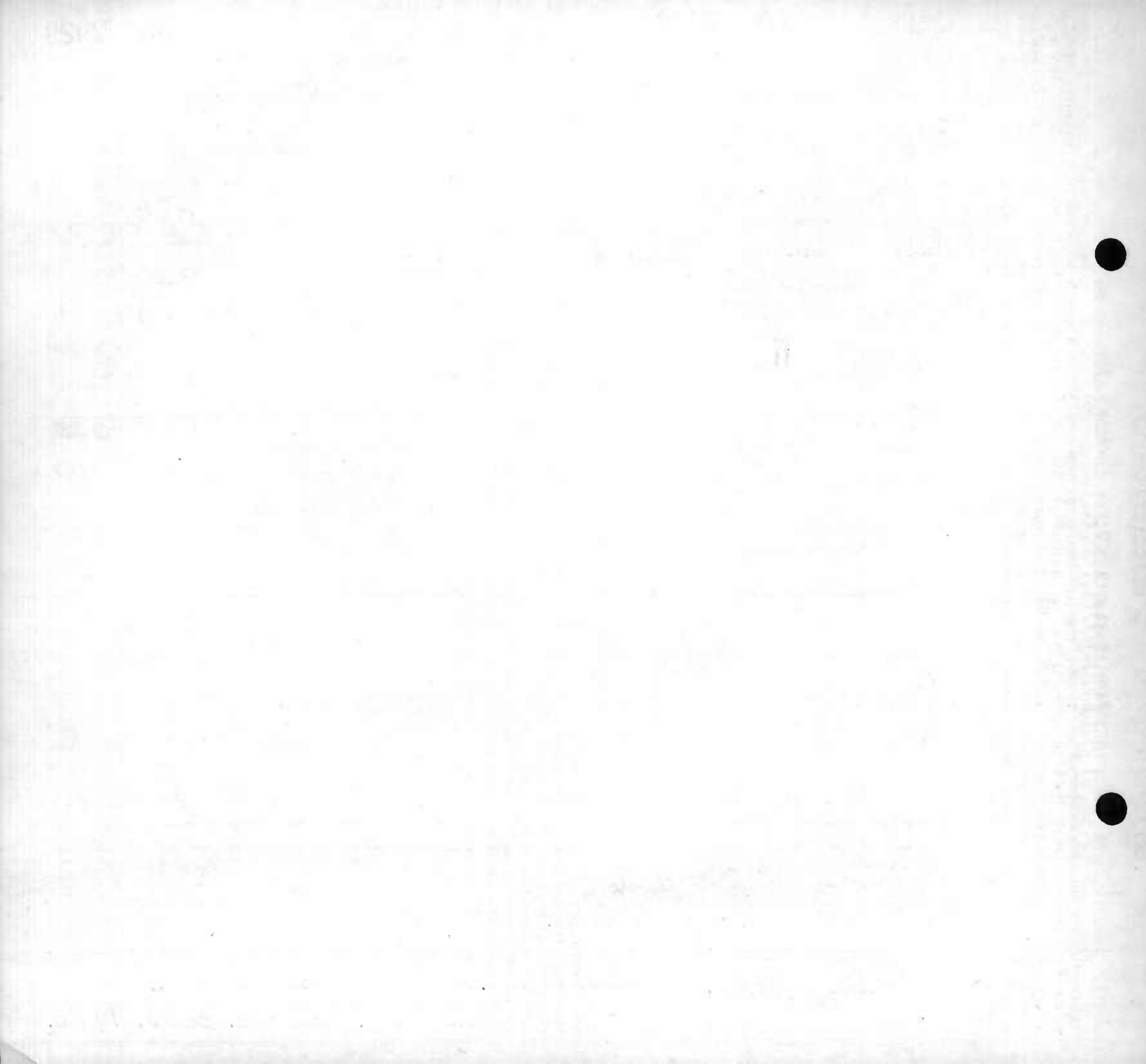
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7028	
BIRTH NO. 65 7028		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ARMETTA, ROSALIE ANGELINE		2. DATE AND HOUR OF DEATH JULY 1, '65 10:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		A. STATE Maryland B. COUNTY Balto. 53-00		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE (Parkville)	
38		D. STREET ADDRESS (If rural, give location) 9646 Oakdale Ave. #34			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/9/21	9. AGE (In years last birthday) 44	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HW		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME ANDREW R. LOMBARDO (dec.)		14. MOTHER'S MAIDEN NAME Rose Santoni	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. 218051230		17. INFORMANT Mr. Samuel Armetta ADDRESS PATIENT'S Home 9646 Oakdale Ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Mitral Valve Obstruction DUE TO by Intra Mural Thrombosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 1 6/15/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MITRAL & AORTIC VALVE disease		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) X	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) X		21E. INJURY OCCURRED While At Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 65 to 7/1 19 65, that (I) (we) last saw the deceased alive on 7/1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bonni Drani		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED 7/1/65	
23C. PHYSICIAN'S NAME (Type) DR DEMBO - DR COWLEY		M.D. UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/65		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 7029					65 7029				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH				
(Type or Print) BERNARD A. WITTHAUER					JULY 1, 1965 6:15 PM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
(If not in hospital or institution, give street address or location)					A. STATE MD. B. COUNTY 27-05				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
MONTEBELLO STATE HOSPITAL					BALTIMORE 3009 GLENDALE AVE				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED, DIVORCED (specify) Married		7-15-88		76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SUPERVISOR				BALTO. BARGAIN HOUSE		MD.		U.S.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN WITTHAUER					— ? Share				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					HOSPITAL RECORDS		HOSPITAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)					(A) CARCINOMA OF LARYNX			6 YEARS	
ANTECEDENT CAUSES					(B) DUE TO			(C) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO			(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0			NO			NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
<input type="checkbox"/>				<input type="checkbox"/>			<input type="checkbox"/>		
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
<input type="checkbox"/>				<input type="checkbox"/>			<input type="checkbox"/>		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-27 1965 to 7-1 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-1 1965 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
23A. SIGNATURE							23B. DATE SIGNED		
Irving L. Cooperstein M.D.							7-1-65		
23C. PHYSICIAN'S NAME (Type)							23D. ADDRESS		
Irving L. Cooperstein M.D.							MONTEBELLO STATE HOSP.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
Burial			7/6/65.		Parkwood Cemetery			Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
JUL 6 1965			Robert E. F...			Leonard J. Ruck Inc. Balto. 14 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7030				BALTIMORE CITY HEALTH DEPARTMENT		65 7030	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <i>Minnie E. Booth</i>				2. DATE AND HOUR OF DEATH <i>July 2, 1965 11:15 a.m.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY <i>27-05</i>	
<i>6408 Brook Avenue</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>6408 Brook Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>8-15-1874</i>	9. AGE (in years last birthday) <i>90</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Edward Bone</i>				14. MOTHER'S MAIDEN NAME <i>Emily Roberts</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Elizabeth Mabry</i>		
					ADDRESS <i>same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>422.1 I</i>				CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> (B) DUE TO <i>generalized arteriosclerosis</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>many years</i> <i>" "</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>7-2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>6-29-</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Max R. English</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-2-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Max R. English</i>				23D. ADDRESS <i>5713 Belair Rd Baltimore Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>7-5-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Bluefield, W. Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i>		ADDRESS <i>21214</i>	

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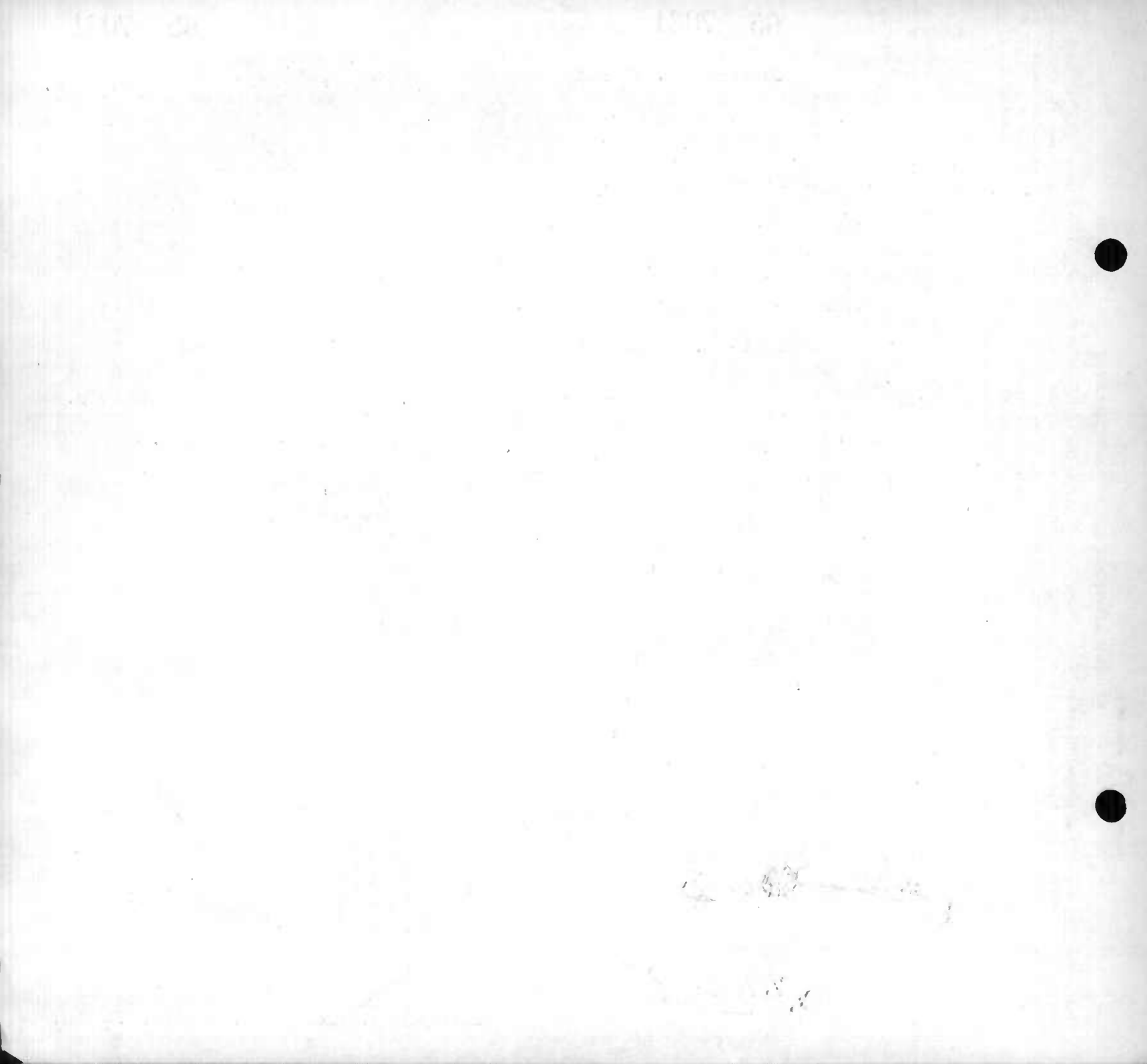
1952

Printed by the University of Chicago Press
Chicago, Illinois

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 7031					Registered No. 65 7031				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Fussell M. Pfeltz</i>					2. DATE AND HOUR OF DEATH <i>July 4, 1965</i> 3:15 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Edgewood Nursing Home</i>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-03</i>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					D. STREET ADDRESS (If rural, give location) <i>2600 Goodwood Rd.</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 3, 1888</i>	9. AGE (In years lost birthday) <i>77</i>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>American Can Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Daniel W. Pfeltz</i>					14. MOTHER'S MAIDEN NAME <i>Annie Rhodes</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-03-2634</i>		17. INFORMANT <i>Lewis W. Pfeltz, Williamsport, Md.</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Atherosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arterio-Vascular Disease</i>					CAUSE OF DEATH (A) DUE TO <i>Arterio-Vascular Disease</i> (B) DUE TO <i>Coronary Atherosclerosis</i> (C) <i>Senility</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>June 25th 1965</i> to <i>July 4th 1965</i> that (I) (we) last saw the deceased alive on <i>July 4th 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>M Paul Byerly</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>7/6/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>M Paul Byerly</i>					23D. ADDRESS M.D. <i>5520 York Rd Balto 12</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. 14 Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 7032 CERTIFICATE OF DEATH					Registered No. 65 7032					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
James F. Mackin Sr.					July 4, 1965. 5:35 A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If instituting residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital					A. STATE Md.					
					B. COUNTY					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore					
					D. STREET ADDRESS (If rural, give location)					
4702 Simms Avenue										
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
Male	White	Married		Dec. 21, 1903	61					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Foreman					Eastern Products		Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
James F. Mackin					Mary S. Mc Kay					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No					214-05-3498		Mrs. Ann M. Mackin		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					(A) <u>Coronary Occlusion</u>					1 hr
					(B) <u>Arteriosclerosis, calcification</u>					3 1/2 hr
					(C) <u>Hypertension, mild</u>					4 hr
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
O										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from <u>7 PM</u> <u>19 65</u> to <u>10 PM</u> <u>19 65</u> that (I) (we) last saw the deceased alive on <u>16 July</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
<u>[Signature]</u>								<u>July 15</u>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
<u>Harold G. Gorman</u>					<u>1604 Hampden Rd</u>			<u>Baltimore (34) Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>7/7/65</u>		<u>Holy Redeemer Cemetery</u>			<u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
<u>JUL 6 1965</u>		<u>R. E. Farley, M.D.</u>			<u>Leonard J. Ruck Inc. Balto.</u>			<u>14 Md.</u>		

CHICAGO, ILL., MAY 1, 1914

TO THE EDITOR OF THE JOURNAL:

SIR:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours,
J. H. HARRIS, M.D.

CHICAGO, ILL.

Enclosed for you are two copies of the report of the committee on the subject of the proposed amendment to the constitution of the American Medical Association.

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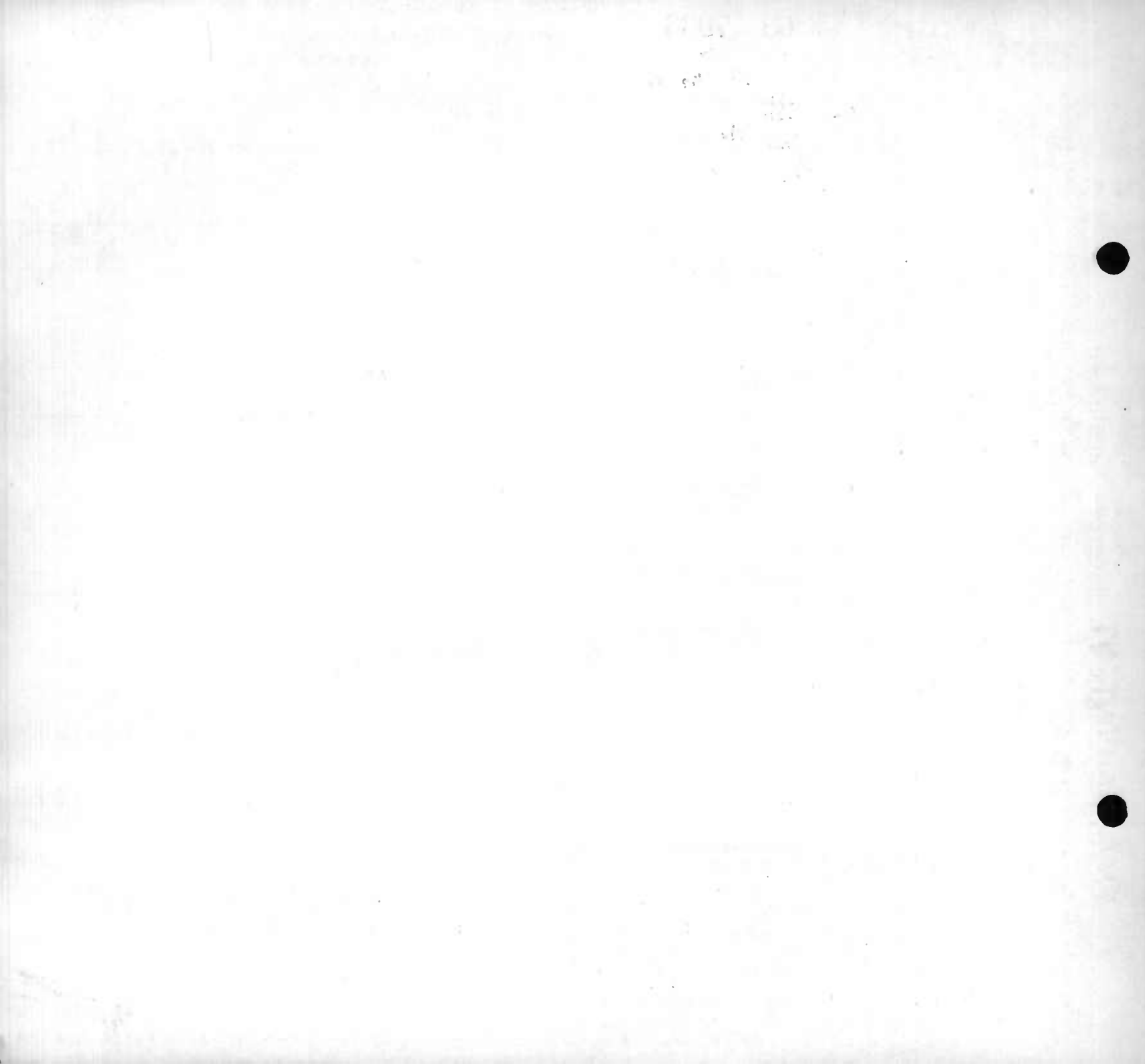
I am, Sir, very respectfully,
Yours,
J. H. HARRIS, M.D.

CHICAGO, ILL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7033	
BIRTH NO. 65 7033		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARY M. LINDSAY</u>		2. DATE AND HOUR OF DEATH <u>JULY 2, 1965</u> <u>10 15</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 Franklin Square Hosp.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>20-01</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1904 Lauretta Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>May 3, 1884</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Nathaniel Hall</u>			
14. MOTHER'S MAIDEN NAME <u>Cornelia Smith</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>260x I</u>		CAUSE OF DEATH (A) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO <u>w/ CEREBRO-VASCULAR ACCIDENT, OLD</u> (B) DUE TO <u>DIABETES MELLITUS</u> (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 13</u> 19 <u>65</u> to <u>July 2</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>July 2/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>BENIGNO M. OTEY 2A</u>		23D. ADDRESS <u>5506-4 REECHES RD., BALT. 21206</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-65</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Ed. J. Watson</u>	
				ADDRESS <u>1000 Brantley Ave.</u>	



RELEASE D BY DR. HOUSER OF MEDICAL EXAMINERS OFFICE AS NON MEDICABLES, SAMPLE 725897

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

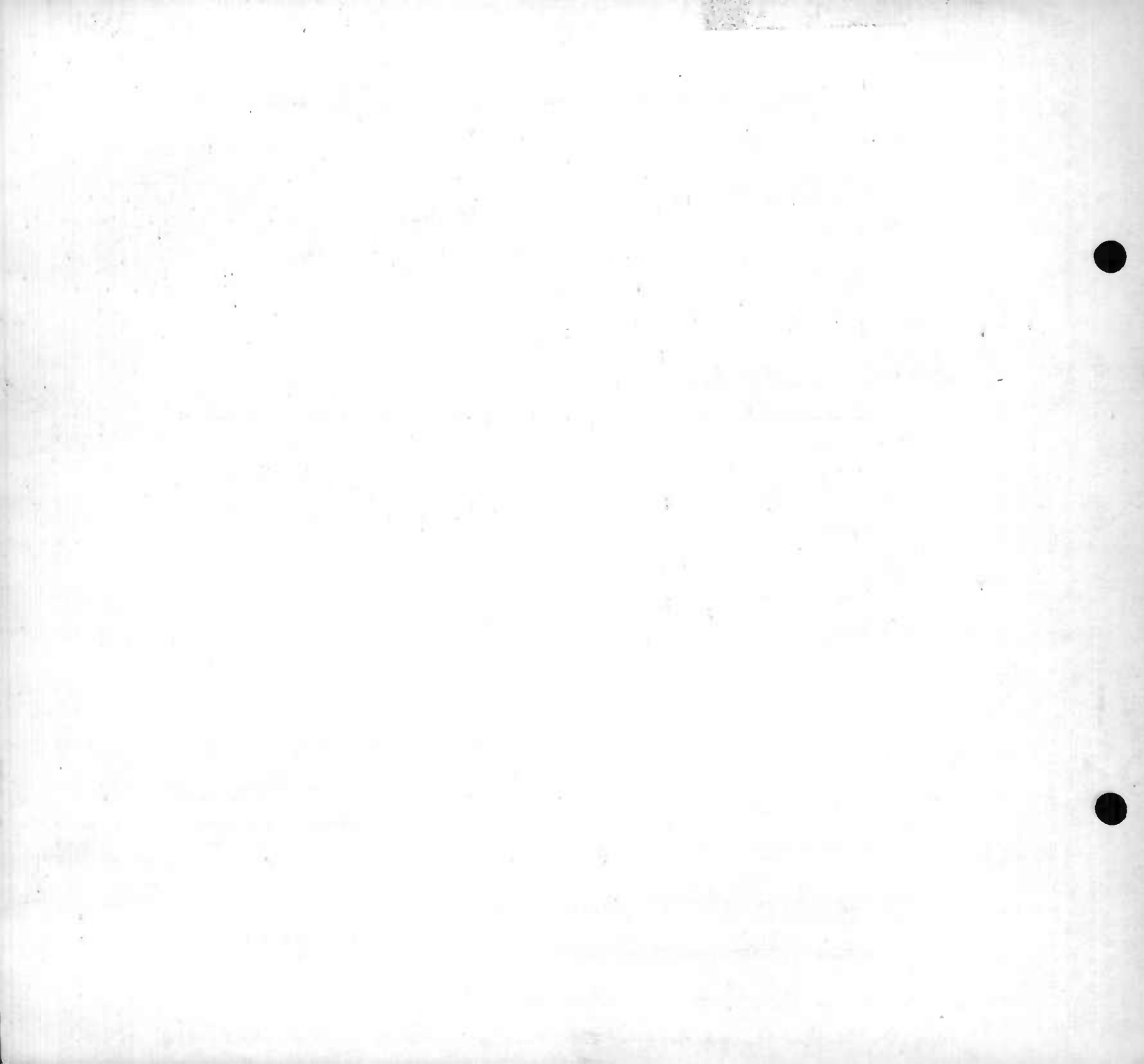
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 7034

BIRTH NO. <u>W-452</u>		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) WILLIAMS, SARAH		2. DATE AND HOUR OF DEATH 7-2-65 10:32 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) EDGEWATER AA 52-00 D. STREET ADDRESS (If rural, give location) 72865X RTE 2, Box 120	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-15-84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) 80
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAUDES MOORE, PETERS		14. MOTHER'S MAIDEN NAME MARY JAMES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Bessie Johnson 24 parcel st.
18. 570.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) SEVERE DEHYDRATION DUE TO E ELECTROLYTE DERANGEMENT (B) CHRONIC COMPLETE DUE TO INTESTINAL OBSTRUCTION (C) _____ INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS 3-4 DAYS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC CONGESTIVE HEART FAILURE PULMONARY FIBROSIS			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-1-65 19 to 7-2-65 19, that (I) (we) last saw the deceased alive on 7-2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James A. Harper MD.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 7-2-65
23C. PHYSICIAN'S NAME (Type) JAMES A. HARPER		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/7/65	24C. NAME OF CEMETERY or CREMATORY Fowlers	24D. LOCATION (City, town, or county) (State) Best Gate, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1965	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS William Reese II Annapolis, Md.	



FUNERAL DIRECTOR: IMPORTANT

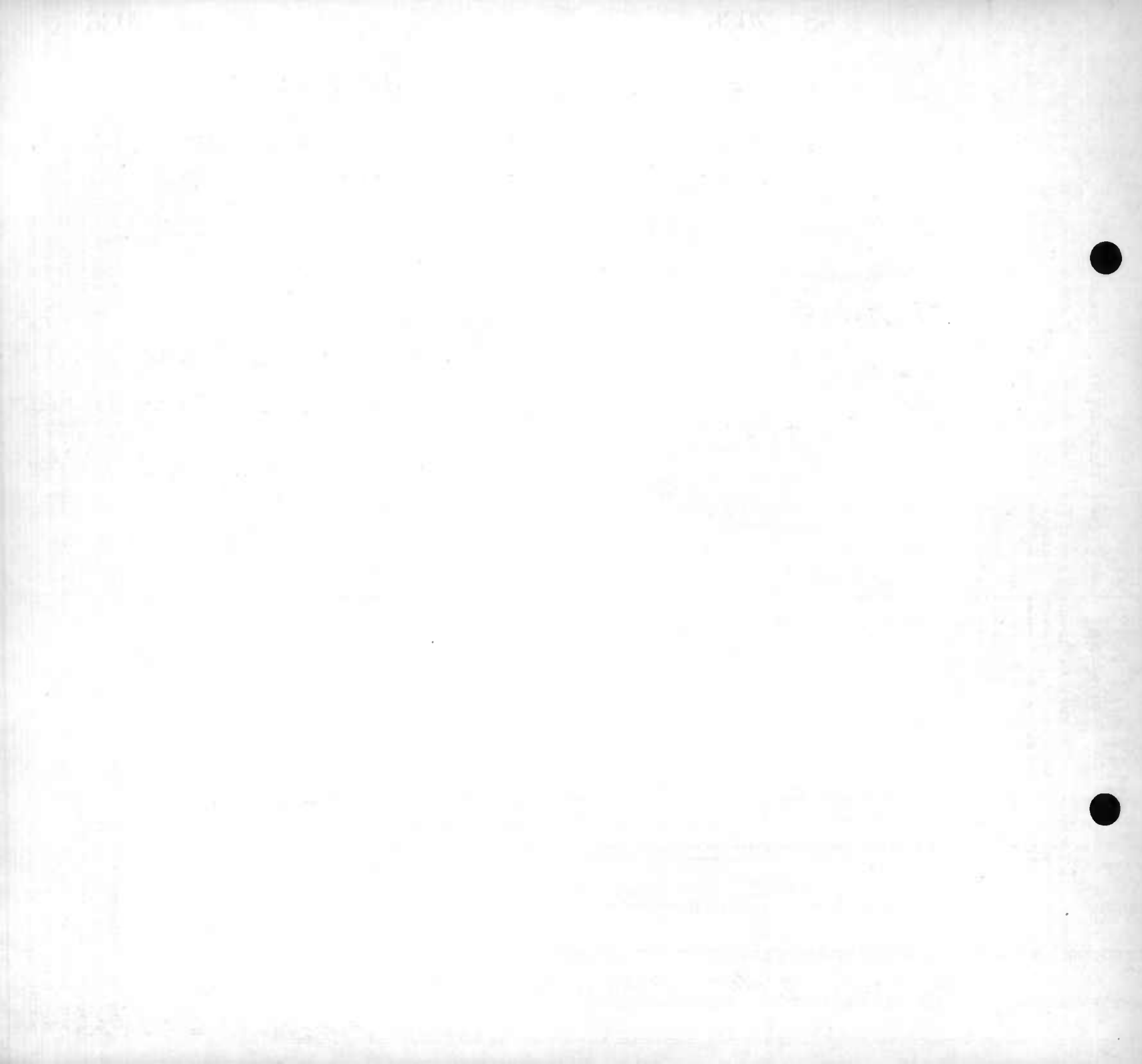
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7035	
BIRTH NO. 65 7035		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edna G. Hanson		2. DATE AND HOUR OF DEATH 7-6-65 8¹⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE Maryland 6. COUNTY 12-11	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 116 W. University Parkway			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-6-94	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY OFFICE		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Washington Hanson		14. MOTHER'S MAIDEN NAME Katherine Haas	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-1127		17. INFORMANT MRS. J. E. EDENFIELD - BROADVIEW APTS	
18. I 190X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Renal Carcinoma		3 yrs	
		(C)		SHL	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18-65 to 7-6-65 , that (I) (we) last saw the deceased alive on 7-6-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodney L. Brimhall		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-6-65	
23C. PHYSICIAN'S NAME (Type) RODNEY L. BRIMHALL		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/8/65	24C. NAME OF CEMETERY or CREMATORY MT CARMEL CEM		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME 4210 BELAIR	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 7036					65 7036				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) DONNETTE WEIS (AKA DONETTA)					2. DATE AND HOUR OF DEATH 7-3-65 230PM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 43 SOUTH BALTIMORE GENERAL HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY SOUTH				
5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW					8. DATE OF BIRTH 2-22-90 9. AGE (In years last birthday) 75				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME					11. BIRTHPLACE (State or foreign country) MARYLAND				
10B. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME WILLIAM LILLY					14. MOTHER'S MAIDEN NAME REBECCA LEBRUN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 214-01-4091B				
					17. INFORMANT ROBERT J WEIS, JR ADDRESS 421 S. 52ND ST				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 422.1 + 260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus					CAUSE OF DEATH (A) Coronary Heart Failure 1 1/2 MONTHS DUE TO (B) ASCVD DUE TO (C)				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 6-24 19 65 to 7-3 19 65 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE D. M. Kauf					23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) M.D.					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 7/6/65				
24C. NAME OF CEMETERY or CREMATORY PARK WOOD CEMETERY					24D. LOCATION (City, town, or county) (State) PARKVILLE MD				
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965					25B. NAME OF REGISTRAR Robert E. Farber				
25C. FUNERAL DIRECTOR UULRICH FUNERAL HOME					25D. ADDRESS 4210 BELMONT				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7037	
BIRTH NO. 65 7037		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William J. Roemer		2. DATE AND HOUR OF DEATH July 5, 1965 7:15 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 27-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3404 Parkside Drive		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3404 Parkside Drive			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 30, 1882	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Cemetery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Conrad Roemer		14. MOTHER'S MAIDEN NAME Margaret Fisher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-8657		17. INFORMANT ADDRESS Mrs. Lottie Roemer 3404 Parkside Drive	
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Arteriosclerosis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 4 19 65 to July 5 19 65 , that (I) (was) lost saw the deceased alive on July 4 19 65 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman		23D. ADDRESS 3202 Harford Road			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Parkville, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road.	

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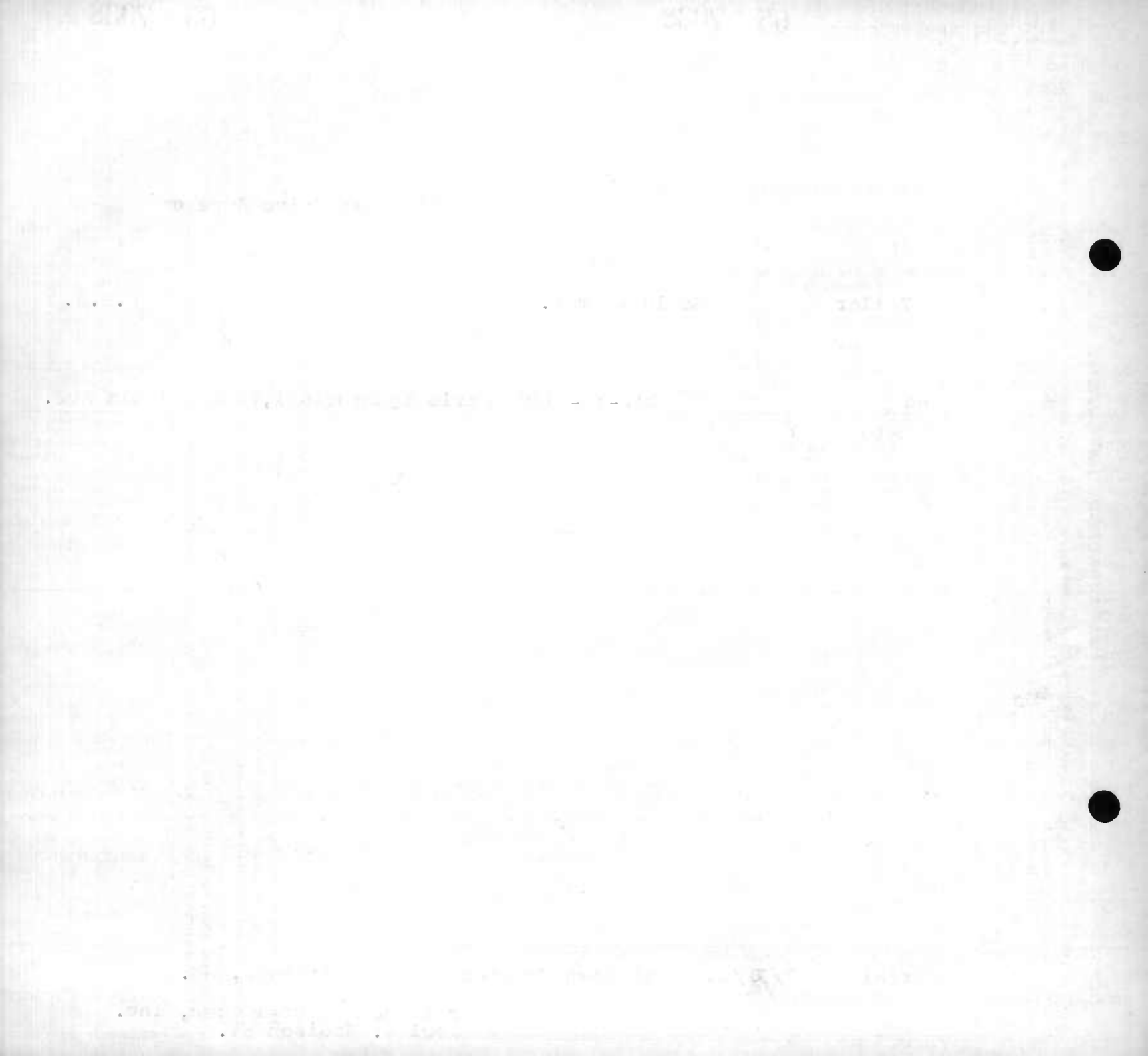
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10/10/01
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

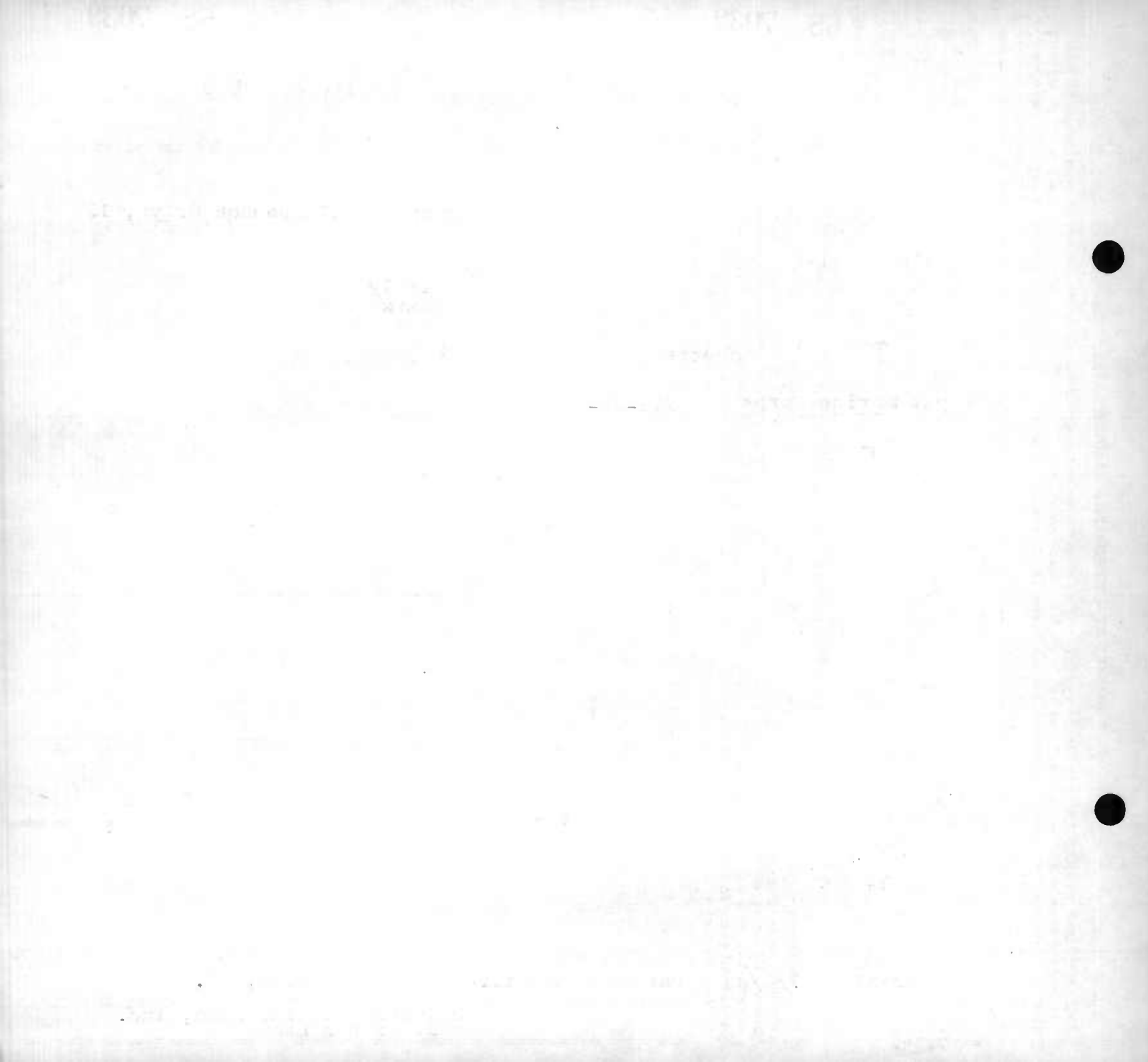
BIRTH NO. 65 7038		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7038	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) FRANK KUTCHER		
2. DATE AND HOUR OF DEATH JULY 4, 1965 2:30 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00		
			D. STREET ADDRESS (If rural, give location) 9413 Dawn Drive Zone 600.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 5.2.81	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Schloss Bros.		11. BIRTHPLACE (State or foreign country) CZECH	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALBERT KUTCHER		14. MOTHER'S MAIDEN NAME ANNA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-10-0139		17. INFORMANT ADDRESS Marie Ignatorowski, 7609 Wilhelm Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.0 + 260X (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			(A) COMPLETE HEART BLOCK. DUE TO DUE TO MIND.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CARDIAL ARREST, irreversible due to above		
			(C) Congestive heart failure		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			DIABETES MELLITUS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 19 65 to July 4 19 65, that (I) (we) last saw the deceased alive on July 4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE A. Nahum, M.D.			23B. DATE SIGNED 7.4.65		
23C. PHYSICIAN'S NAME (Type) ALBERT NAHUM			23D. ADDRESS CHURCH HOME & HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/18/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 7 1965		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.					



FUNERAL DIRECTOR: IMPORTANT

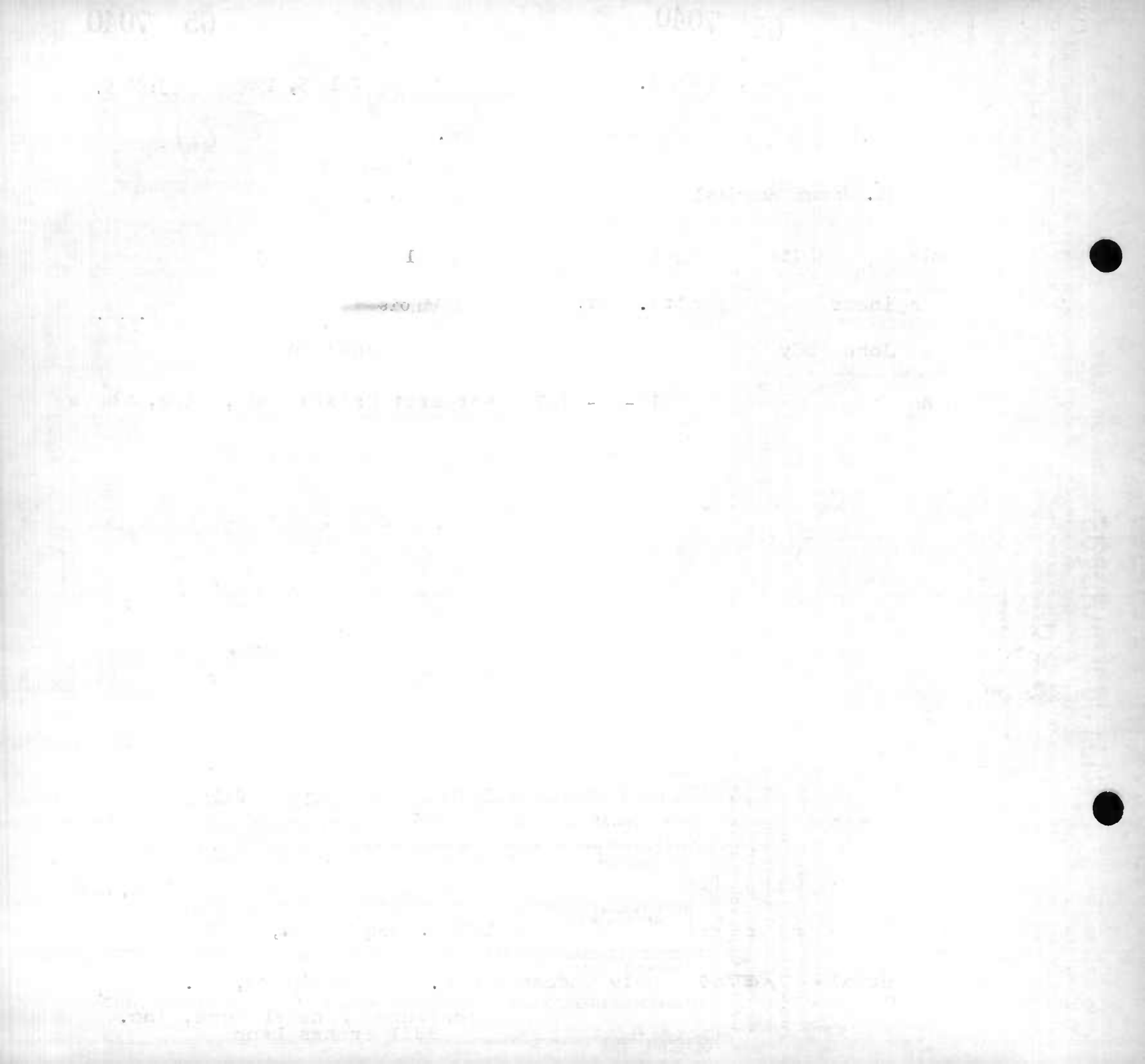
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7039		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7039	
M.E. CASE NO.		CERTIFICATE OF DEATH		1	
1. NAME OF DECEASED (Type or Print) <u>Roberts, Joseph L.</u>			2. DATE AND HOUR OF DEATH <u>July 3, 1965</u> <u>2:15 a.m.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>26-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3327 Shannon Drive, 13</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8/30/92</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>
13. FATHER'S NAME <u>Leonard Roberts</u>			14. MOTHER'S MAIDEN NAME <u>Patricia ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes Marine Corps</u>			16. SOCIAL SECURITY NO. <u>216-38-2980</u>		17. INFORMANT <u>Hosp. record.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>ASCVD</u> DUE TO (B) <u>Myocardial infarction</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 30</u> 19 <u>65</u> to <u>July 3</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>July 3</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>7-3-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/6/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>	
25D. ADDRESS					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

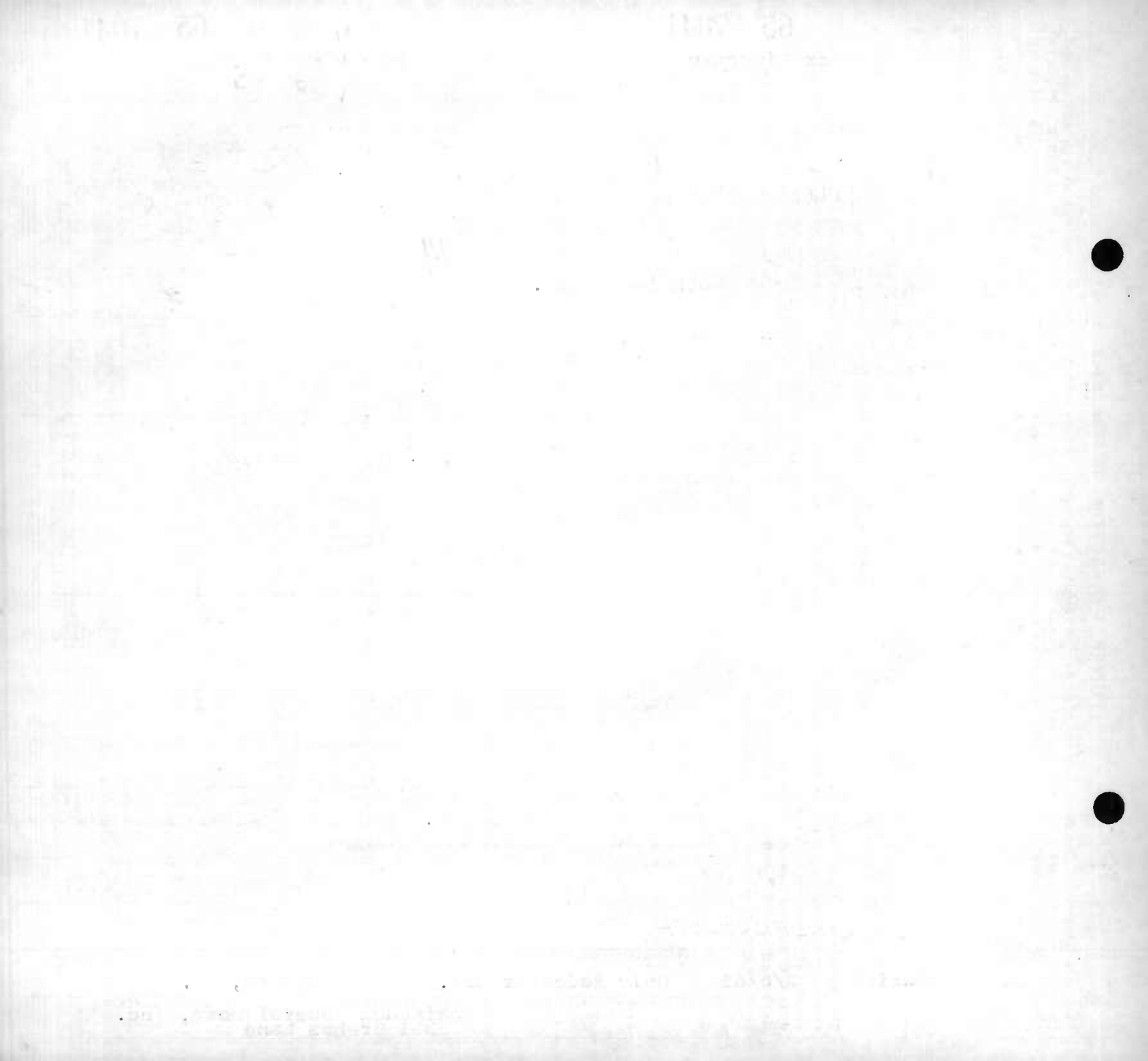
BIRTH NO. 65 7040				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7040	
1. NAME OF DECEASED (Type or Print) FODY, ELMER F.				2. DATE AND HOUR OF DEATH July 5, 1965 3:20 A.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 41 St. Joseph Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 8-81 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 13 D. STREET ADDRESS (If rural, give location) 3209 Belair Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/6/01	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fody			14. MOTHER'S MAIDEN NAME unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-05-8127		17. INFORMANT ADDRESS Margaret Erlein Fody, wife, above			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Massive pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 3 19 65 to July 5 19 65 , that (I) (we) last saw the deceased alive on July 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Govinda Rao M.D.				23B. DATE SIGNED July 5, 1965			
23C. PHYSICIAN'S NAME (Type) Govinda Rao				23D. ADDRESS M.D. 1400 N. Caroline St., 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Fody		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 7041						CERTIFICATE OF DEATH			Registered No. 65 7041		
M.E. CASE NO.						1. NAME OF DECEASED or Vincenzo Albione			2. DATE AND HOUR OF DEATH 4-2-65 40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE Maryland			B. COUNTY		
Maryland General Hospital						C. CITY OR TOWN Baltimore			If outside city limits, write RURAL and give township		
						D. STREET ADDRESS 7821 Wendover Ave			If rural, give location		
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11-14-91		9. AGE (In years last birthday) 73		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Matheison Chem.				11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A. NATURALIZED	
13. FATHER'S NAME Vincent Albione						14. MOTHER'S MAIDEN NAME ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES						(A) DUE TO Acute Myocardial Infarct				12 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO Coronary Thrombosis				" "	
						(C) ASCVD					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-20-19-65 to 7-2-19-65, that (I) (we) last saw the deceased alive on 7-2-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE DR. LINDEN STRUTH						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-2-65			
23C. PHYSICIAN'S NAME (Type) DR. LINDEN STRUTH						23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/6/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			



BIRTH NO. 65-08622 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) Ann CATHLEEN PARROTT		2. DATE AND HOUR PRONOUNCED DEAD 7-4-65 12:22 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL - DOA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 53-00 5705 Leiden Road	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 3/27/1965
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 3 mos.
13. FATHER'S NAME Earl R. Parrott, Jr.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY?
17. INFORMANT Earl R. Parrott, Jr., father, above		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Meningitis. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/6/65	23C. NAME of CEMETERY or CREMATORY Baltimore Cemetery
24A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		24B. NAME OF REGISTRAR Robert E. Farley, M.D.	24C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc., 2601 E. Madison St.
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		ADDRESS	

WALLACE

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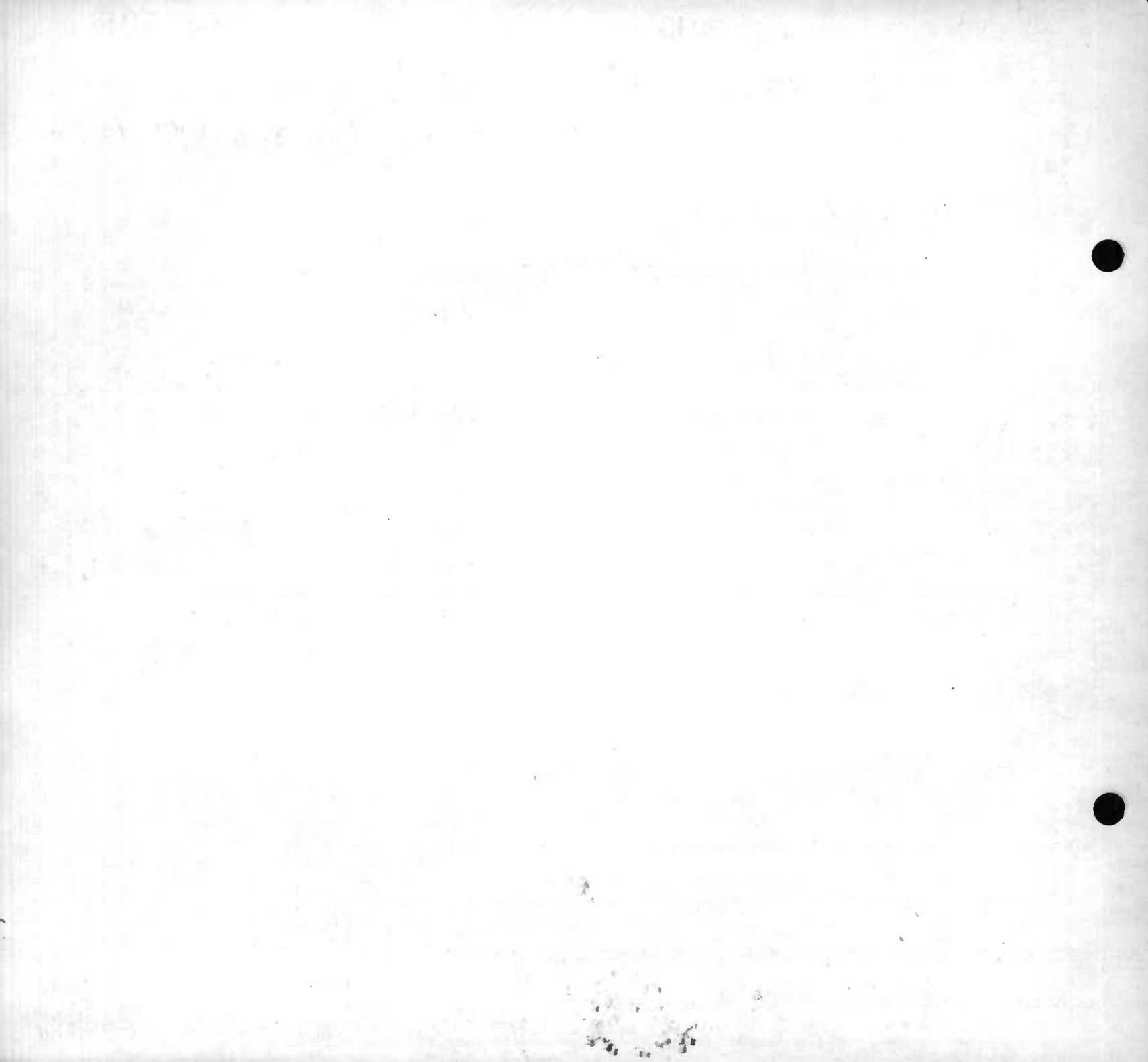
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 7043		CERTIFICATE OF DEATH		65 7043	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		FORWOOD JULIA		7-1-65 11:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
MERCY HOSPITAL		MD.		MIDTOWN NURSING HOME	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
		BALTIMORE		11-02	
		D. STREET ADDRESS		(If rural, give location)	
		808 ST. PAUL ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED	6-17-84	81 YRS.	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
GARY LEVERTON		UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				THOS. FORWOOD = 917 MAIDEN CHOICE LANE ARBUTUS MD.	
18. 422.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Centrovaxen pneumonia</i>		1 hr	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		DUE TO <i>Centrovaxen shock</i>			
ANTECEDENT CAUSES		(B) <i>Auto Coagulation Heart failure</i>		days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO <i>ASCVD</i>		yrs.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 7-1-65 (11:05 pm) 19 to 7-1-65 (11:25 pm) 19, that (I) (we) last saw the deceased alive on 7-1-65 (11:25 pm) 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D.	Attending Phys. <input type="checkbox"/>	Med. Director <input type="checkbox"/>	Staff Phys. <input checked="" type="checkbox"/>
Carmelita A. Cendano					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23B. DATE SIGNED	
		M.D. Mercy Hospital		7-1-65	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	JULY 3	CHESTER		CHESTERTOWN MD.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUL 7 1965	Robert E. Farkner	Edgar L. Lane Church Hill Ind.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 7044		CERTIFICATE OF DEATH		65 7044	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		ELLEN FLORENCE KEYS		7/4/65 3:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (If here deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
42 SINAI HOSPITAL		MD		13-08	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTO.			
		D. STREET ADDRESS (If rural, give location)			
		1310 Union Ave. #11			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	WIDOWED, DIVORCED (specify) WIDOW	3/5/87	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TEXTILE WORKER		COTTON MILL		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WILLIAM HENRY EVANS		ROSA SHIPLEY		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
170		216-04-9460		JAMES W. KEYS 1310 UNION AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1 1965 to July 4 1965, that (I) (we) last saw the deceased alive on July 4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Guarardo M. Gifford				7/4/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		JULY 7-1965		MORGAN CHAPEL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 7 1965		Robert E. Farley		BURGEE FUNERAL HOME 3631 FALLS ROAD	

BIRTH NO. 65 7045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7045

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ETHEL M. COOPER

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1965 5:05 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rosedale

D. STREET ADDRESS (If rural, give location)

1221 Chesco Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Oct. 15, 1899

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

F. H. Rawlinson

14. MOTHER'S MAIDEN NAME

Edith Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Bilateral Pulmonary Emboli
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Thrombophlebitis, Deep Venous, Right Leg.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7 9 1965

23C. NAME of CEMETERY or CREMATORY

Balto. U. S. National

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave.

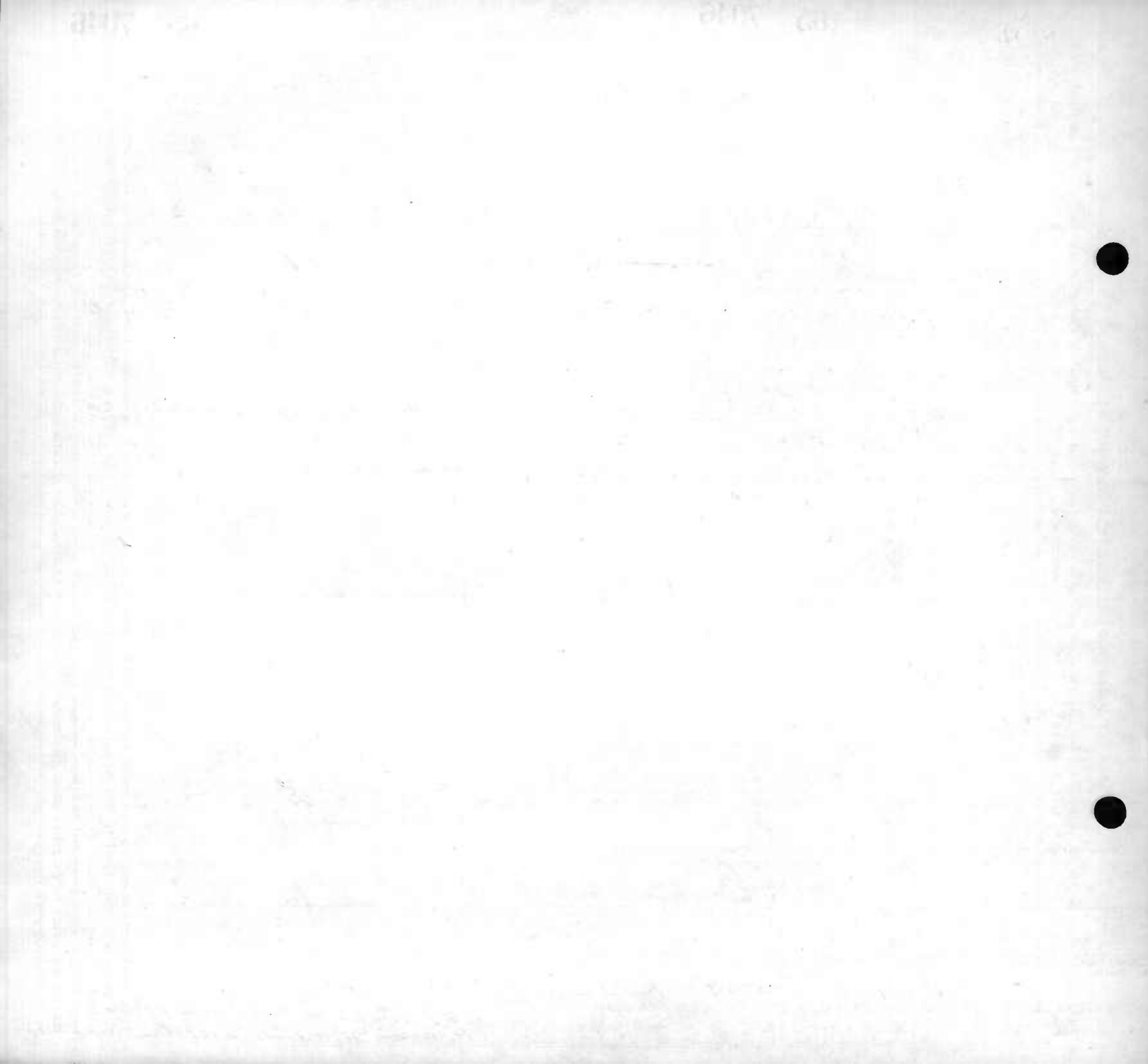
AND THE ...

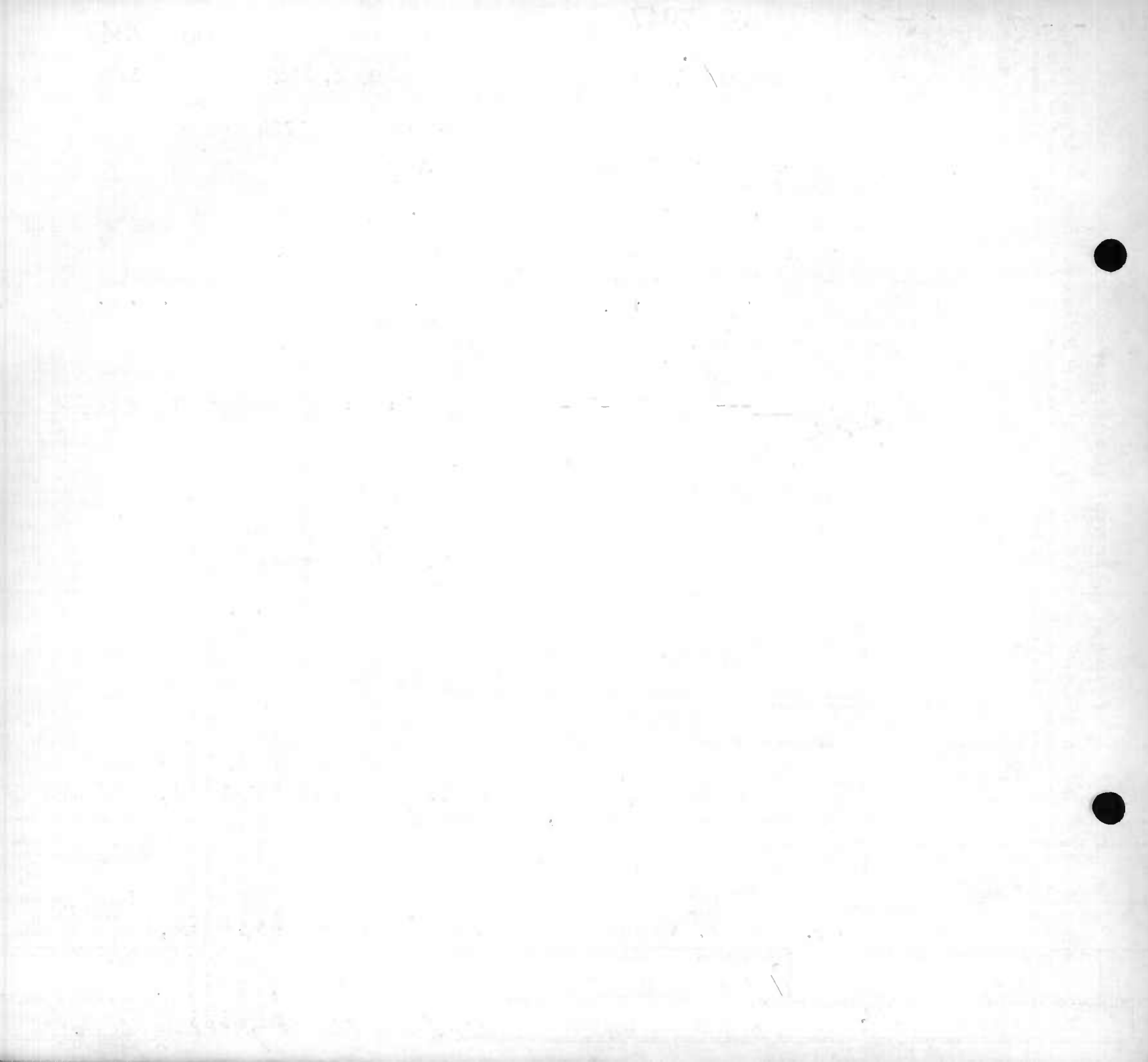
Charles ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7046				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7046	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FANNIE L U H				2. DATE AND HOUR OF DEATH 7-5-65 7:40 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Mecky Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 25-41	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3558 Benzinger Rd			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-19-86	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Morgan				14. MOTHER'S MAIDEN NAME Minnie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Mrs. HAMMOND 3558 BENZINGER RD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest				CAUSE OF DEATH Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic coronary Vascular disease							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 04-23-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured Hip		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3558 Benzinger Rd. 25-41			
21D. TIME OF INJURY (APPROX.) 4 17 65 839		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Lost balance + fell to floor			
22. I certify that (I) (this hospital) attended the deceased from 4-17-65 to 7-5-65 and that in (my) (our) opinion death occurred on the date 7-5-65 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Frank L. Barham M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-5-65	
23C. PHYSICIAN'S NAME (Type) Frank L. BARHAM				23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-6-65		24C. NAME OF CEMETERY or CREMATORY Louisa Park		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert S. Taylor		25C. FUNERAL DIRECTOR GEO. L. Schwab Funeral Home & Home 2101 Frederick Ave			





BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65 7048

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 7048

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALICE

ANN

JOHNSON

C Williams

2. DATE AND HOUR PRONOUNCED DEAD

July 1, 1965

7:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

11 E. Chase Street

8/2/65

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

242 S. Collington Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED,
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Sept. 11, 1946

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Secretary

10B. KIND OF BUSINESS OR INDUSTRY

Professional

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry S. Johnson

14. MOTHER'S MAIDEN NAME

Alice Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

None

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

Henry S. Johnson

ADDRESS

242 S. Collington

18. E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot Wound of Thorax.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Office

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

11 E. Chase Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

6

30

'65

P.

21E. INJURY OCCURRED

WHILE AT
WORK

X

NOT WHILE
AT WORK

0

21F. HOW DID INJURY OCCUR?

Shot in back.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/65

(Duplicate)

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-6-65

23C. NAME OF CEMETERY or CREMATORY

Bald. Ind.

23D. LOCATION

(City, town, or county)

(State)

Bald. Ind.

24A. DATE REC'D BY HEALTH DEPT.

AUG 2

1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Geo. L. Johnson, Jr., Home

ADDRESS

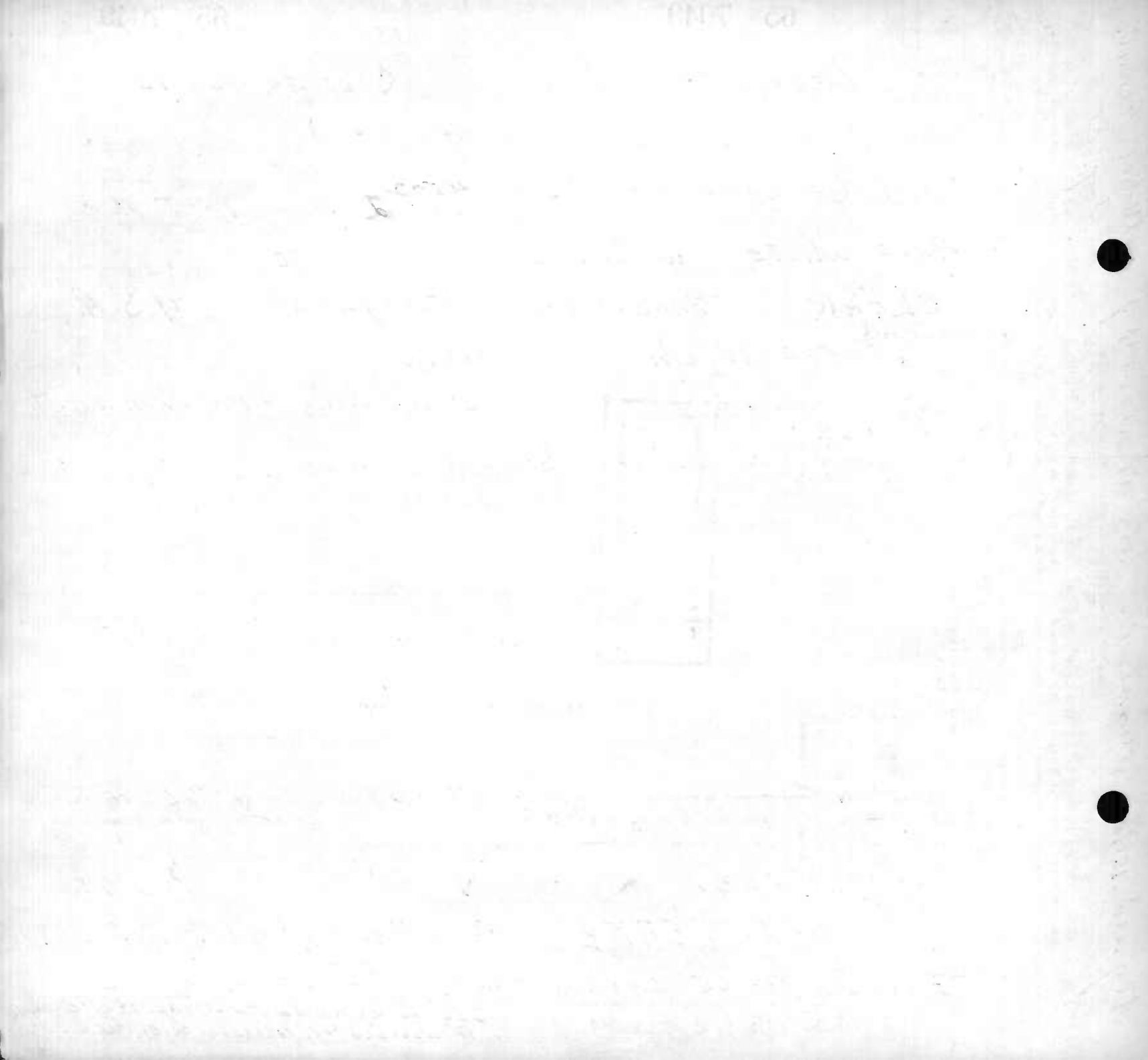
Petition for divorce filed 73B/2069/101557b but divorce action never completed.
Marital status changed from "Divorced" to "Married". Affidavit statement from Informant,
Henry Johnson, that his daughter was separated but not divorced from her husband.

signed with permission and at request of Medical Examiner's Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

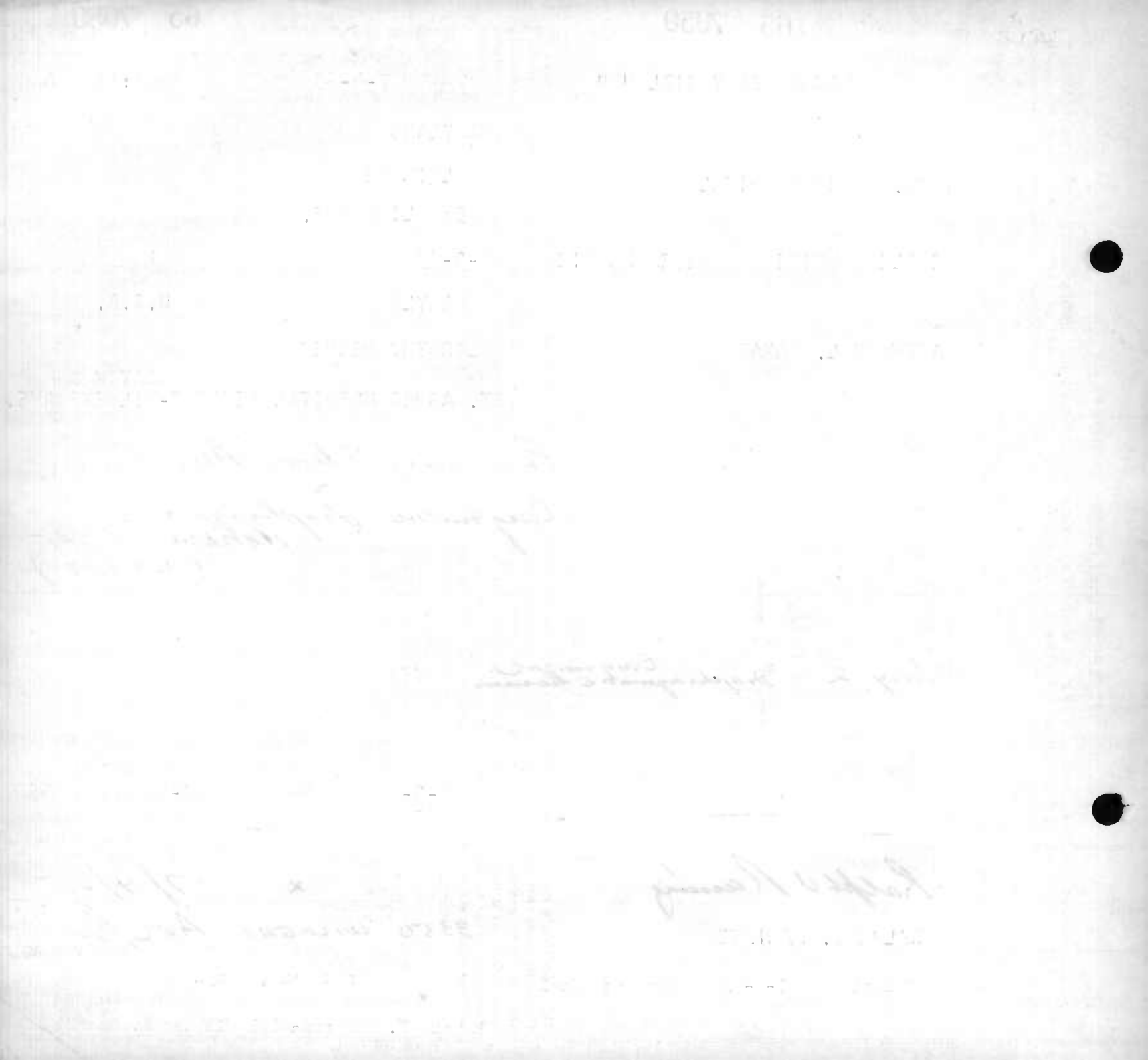
BIRTH NO.		65 7049		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7049	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) George C. Wich				2. DATE AND HOUR OF DEATH JUNE 30, 1965 10:20 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. General Hospital				A. STATE MARYLAND B. COUNTY 27-02			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 4502 HAMPNETT AVE			
5. SEX MALE		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH Aug 26, 1894	
						9. AGE (In years lost birthday) 70	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10B. KIND OF BUSINESS OR INDUSTRY TRANSIT Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME GEORGE WICH			
14. MOTHER'S MAIDEN NAME ROSE				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT VERNON WICH 2104 RAMSAY ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4428 I HYPERTENSIVE CARDIOVASCULAR DISEASE				CAUSE OF DEATH (A) DUE TO Hypertensive cardio vascular renal disease (B) DUE TO (C) _____			
INTERVAL BETWEEN ONSET AND DEATH 3 years							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Emphysema, chronic bronchitis							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-17-65 19 to 6-30-65 19 that (I) (we) last saw the deceased alive on 6-17-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. W. Peake						23B. DATE SIGNED 7-2-65	
23C. PHYSICIAN'S NAME (Type) G. W. PEAKE						23D. ADDRESS 4508 Hanford Rd. Balto 14 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-65		24C. NAME OF CEMETERY or CREMATORY LONDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Geo. L. Schwab FUNERAL HOME Francis H. Miller 2101 Frederick			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-17033 65 7050		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7050	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MAKAR BABY GIRL "B"				2. DATE AND HOUR OF DEATH 7-4-65 1:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5540 LINK AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7-2-65	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min. 1		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANTHONY L. MAKAR				14. MOTHER'S MAIDEN NAME DOROTHY HEANEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CATON & ST. AGNES HOSPITAL RECORDS-WILKENS AVE.			
18. 560.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Pulmonary Edema, Atelectasis DUE TO (B) Congenital Diaphragmatic Hernia DUE TO (C) Hernia (40 hrs)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION July 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital Diaphragmatic Hernia		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-2- 19 65 to 7-4 19 65 , that (I) (we) last saw the deceased alive on 7-4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Ralph V. Ramirez				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/4/65	
23C. PHYSICIAN'S NAME (Type) RALPH V. RAMIREZ				23D. ADDRESS 3350 WILKENS AVE, Baltz			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-6-65		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Ralph E. Farber		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Avenue 21229			



65 7051		BALTIMORE CITY HEALTH DEPARTMENT		65 7051	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		D. HAROLD METZ		2. DATE AND HOUR PRONOUNCED DEAD July 3, 1965 3:45 p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1312 Maple Avenue	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-6-19	9. AGE (In years last birthday) 46	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Lumber Co.		11. BIRTHPLACE (State or foreign country) Parsons, West Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Metz		14. MOTHER'S MAIDEN NAME Rose McDonald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Patricia Leatherman-4776 Drayton Green	
18. E976X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple gun shot wounds of head ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7-6-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4813 Elden Green	
21D. TIME OF INJURY (APPROX.) 7 2 65 9:12p		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Shot self in head	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7-6-65		23C. NAME OF CEMETERY or CREMATORY St. George Cemetery	
23D. LOCATION (City, town, or county) (State) St. George, West Virginia		24. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
24A. NAME OF REGISTRAR Robert E. Farkas, M.D.		24C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Avenue 21229			

MEMORANDUM FOR THE DIRECTOR, FBI

RE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

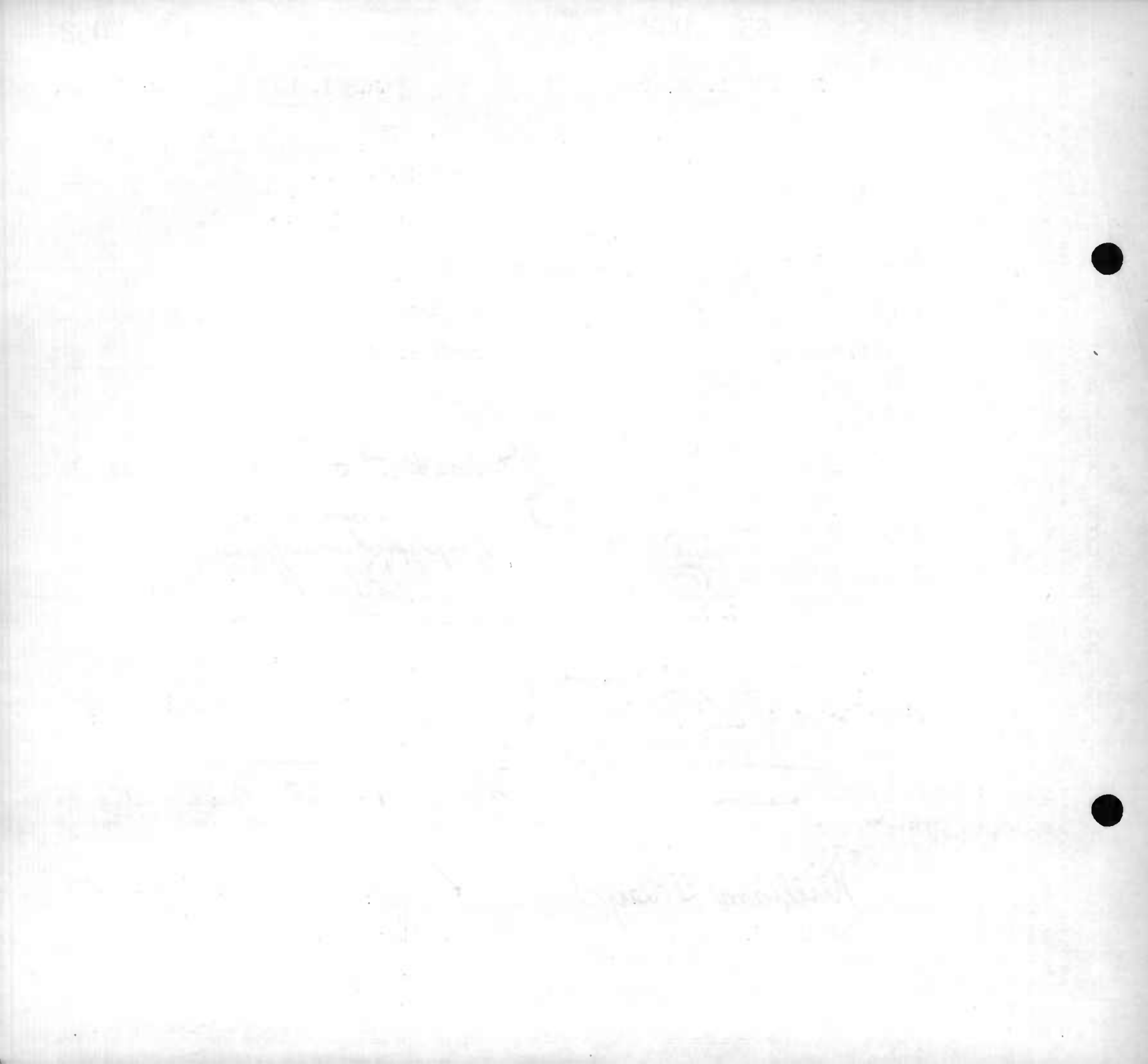
7. [Illegible]

8. [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7052				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED No. 65 7052	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LILLIAN E. GERWIG				2. DATE AND HOUR OF DEATH July 1, 1965 6:30 P.M. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines - Belair				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 6-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2524 E. Fayette St.			
5. SEX Female	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH April 16, 1883	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At. Home			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME John P. Gerwig			14. MOTHER'S MAIDEN NAME Annie E. Vickers				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. John Leonard 2706 Erdman Ave.		
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardio (B) DUE TO Basal Renal Disease (C) Myocardial Insufficiency Pulmonary Embolism		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this physician) attended the deceased from June - 1 - 1965 to June - 30 - 1965 , that (I) (we) last saw the deceased alive on June 30 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE William G. Geyer M.D.				23B. DATE SIGNED July - 2 - 65			
23C. PHYSICIAN'S NAME (Type) William G. Geyer,				23D. ADDRESS M.D. 156 N. Milton Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-3-65	24C. NAME OF CEMETERY or CREMATORY Landon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7053		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7053	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FREDERICK PLATO REED		2. DATE AND HOUR OF DEATH JUNE 30 1965 7 45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 THE UNION MEMORIAL HOSPITAL		A. STATE MD B. COUNTY 26-03			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3058 MAYFIELD AVENUE			
5. SEX MALE	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-24-1890	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE ROOM-MGR		10B. KIND OF BUSINESS OR INDUSTRY GAS & Electricity		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U S		13. FATHER'S NAME JOHN REED			
14. MOTHER'S MAIDEN NAME MARY WINSTON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS ISABEL S. REED 3058 MAYFIELD			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 5810-110-1X		CAUSE OF DEATH (A) BLEEDING ESOPHAGIAL VARICES 2 MONTH DUE TO (B) LIVER CIRRHOSIS AND (C) CARCINOMA OF THE STOMACH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 16-23-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED UPPER G-I BLEEDING		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from JUNE 5 19 65 to JUNE 30 19 65 , that (B) (we) last saw the deceased alive on JUNE 30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE A. C. CHEN				23B. DATE SIGNED 6-30-65	
23C. PHYSICIAN'S NAME (Type) A. C. CHEN				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-65		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE COUNTY, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS ULLRICH FUNERAL HOME, BALTO, MD.			

THE ONLY MEMORIAL BUILT FOR THE
MALE W. 1914-1915
AND 1916-1917
TOM R. 1918

When cleared for
operation of the road

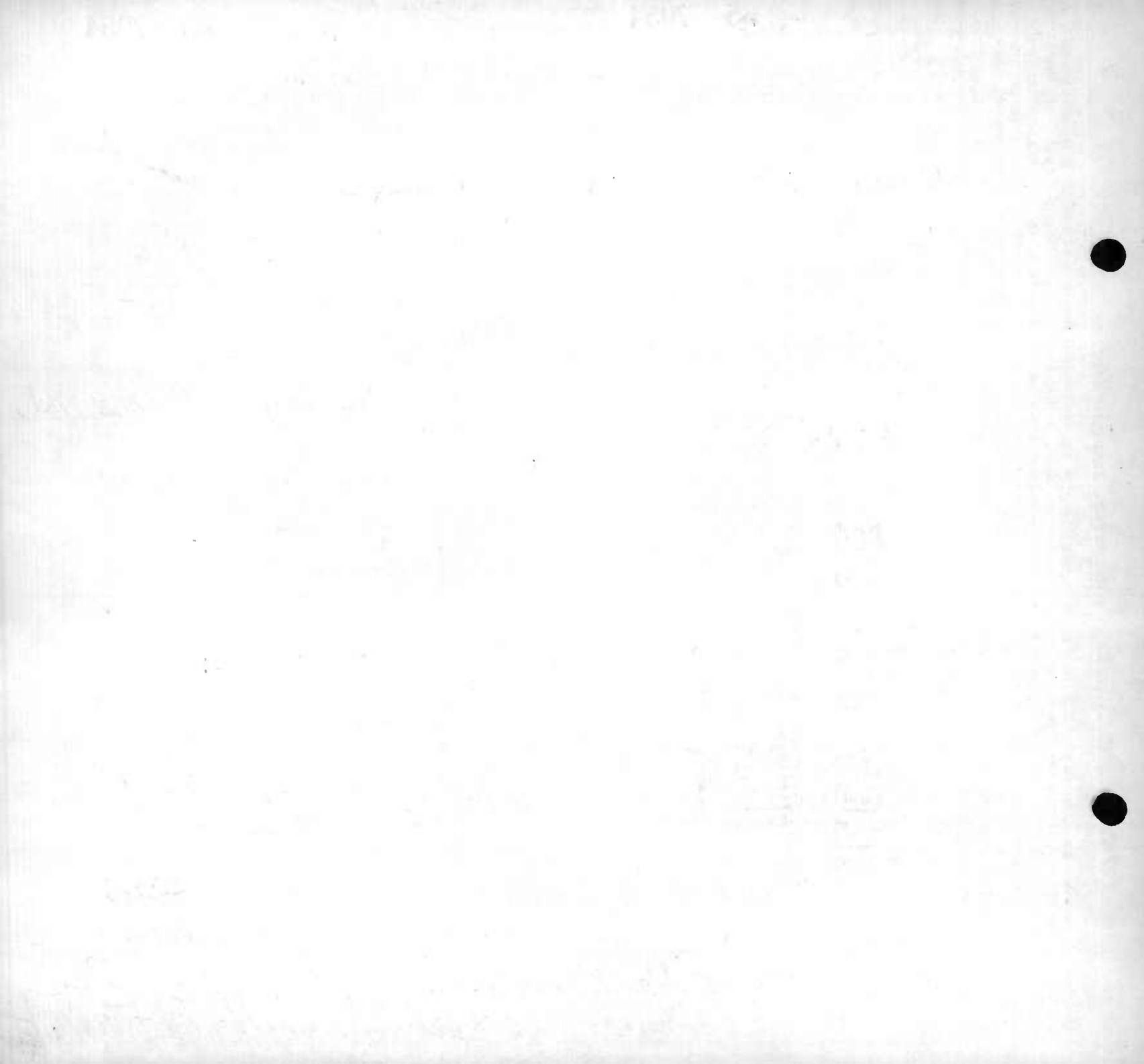
Revised - 1918

[Signature]
A. C. CHEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>65</i> <i>7054</i>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>65</i> <i>7054</i>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>WROTEN, BONNIE</i>		2. DATE AND HOUR OF DEATH <i>3:25am 7/3/65</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>33</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>VIENNA</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>VIENNA</i> <i>59-00</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		D. STREET ADDRESS (If rural, give location) <i>?</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>7/9/65</i>	9. AGE (In years last birthday) <i>7</i>	If Under 1 Yr. Months Days Hours Min. <i>6</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>MATTHEW Wroten</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Harley</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>RUTH Harley</i> ADDRESS <i>Vienna Md.</i>	
18. <i>086X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Aspiration</i> DUE TO (B) <i>VIRAL PNEUMONITIS</i> DUE TO (C) <i>RUBELLA SYNDROME</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>7-2-64</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>LUNG ASPIRATION</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NO</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NO</i>	
21D. TIME OF INJURY (APPROX.) <i>NO</i>		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>JUNE 11</i> 19 <i>65</i> to <i>JULY 3</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>JULY 3</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H.W. Coussons</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/3/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>H.W. COUSSONS</i>		23D. ADDRESS M.D. <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/5/65</i>	24C. NAME of CEMETERY or CREMATORY <i>Dev. Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Cambridge Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Ruth S. Milloy, East New Market</i>	



1

65 7055

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7055

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) PATRICK J. BERRY

2. DATE AND HOUR PRONOUNCED DEAD June 30, 1965 3:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville 53-00

D. STREET ADDRESS (If rural, give location) 308 Patleigh Road

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) INSTITUTION 38 University Hospital

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED

8. DATE OF BIRTH APRIL 22, 1957

9. AGE (In years last birthday) 14

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT

10B. KIND OF BUSINESS OR INDUSTRY SCHOOL

11. BIRTHPLACE (State or foreign country) MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME DONALD F. BERRY

14. MOTHER'S MAIDEN NAME MINERVA WINTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Donald F. Berry - 308 Patleigh Rd.

ADDRESS

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Cerebral Edema and Necrosis DUE TO

II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Contusions. DUE TO

(C)

III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street

21C. WHERE DID INJURY OCCUR? Pratt St. & Hopkins Place 22.01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 6 25 '65 P

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Passenger in auto-auto collision.

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 7/1/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 7-5-65

23C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.

23D. LOCATION (City, town, or county) (State) Baltimore MD

24A. DATE REC'D BY HEALTH DEPT. JUL 7 1965

24B. NAME OF REGISTRAR Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR J. Lee Funeral Home - Catonsville, Md.

ADDRESS

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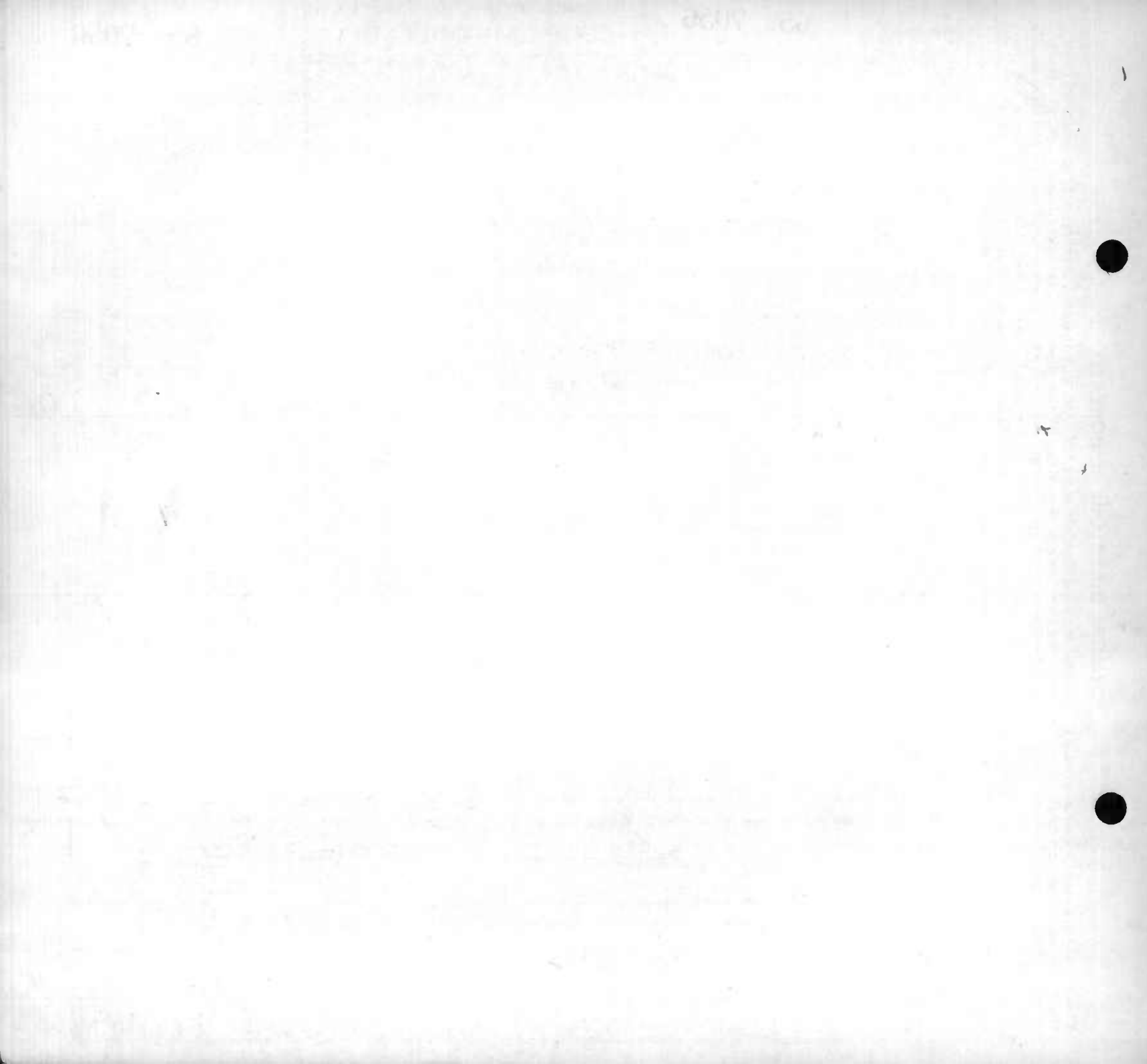
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

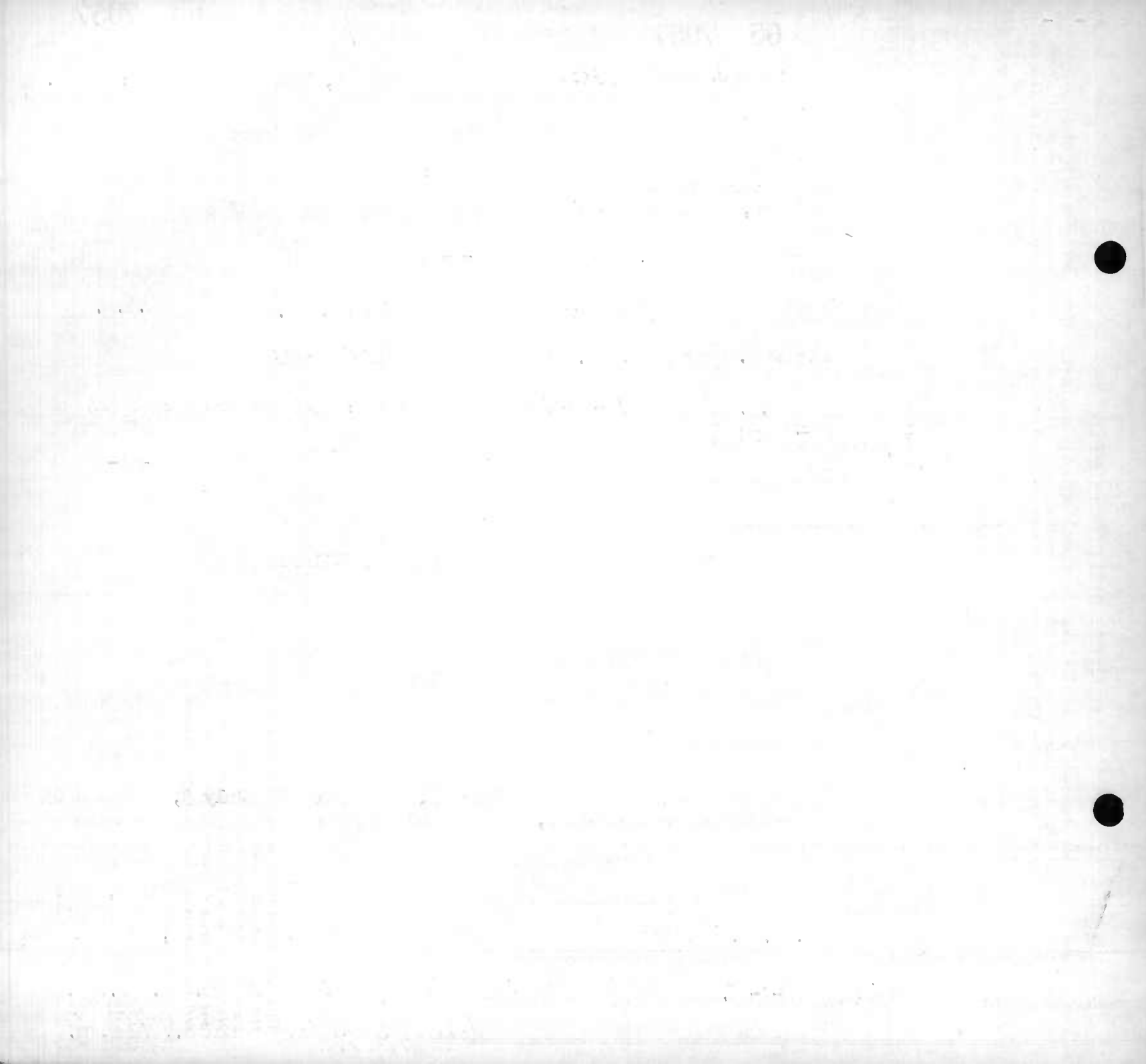
BALTIMORE CITY HEALTH DEPARTMENT									
65 7056					Registered No. 65 7056				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
JESSIE JEFFERSON					7-3-65				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
1303 N. CENTRAL AVE.					Md. 9-09				
5. SEX					6. RACE				
M.					C.				
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)					8. DATE OF BIRTH				
DIVORCED					1-17-02				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country)				
LABORER					NEW PORT NEWS VA.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Cornelius Jefferson					Mary Allen				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					Willis B. Jefferson				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II					1				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					1				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
0									
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
No					No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from					21F. HOW DID INJURY OCCUR?				
July 1 1965					July 3 1965				
23A. SIGNATURE					23B. DATE SIGNED				
Wm. L. Berry					9.3.65				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Wm. L. BERRY					1237 n. Caroline				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					7/7/65				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Mt. Calvary					G. A. County Md.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
JUL 7 1965					Robert E. Taylor				
25C. FUNERAL DIRECTOR					25D. ADDRESS				
Joseph B. Lock Jr.					1304 n. Central				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

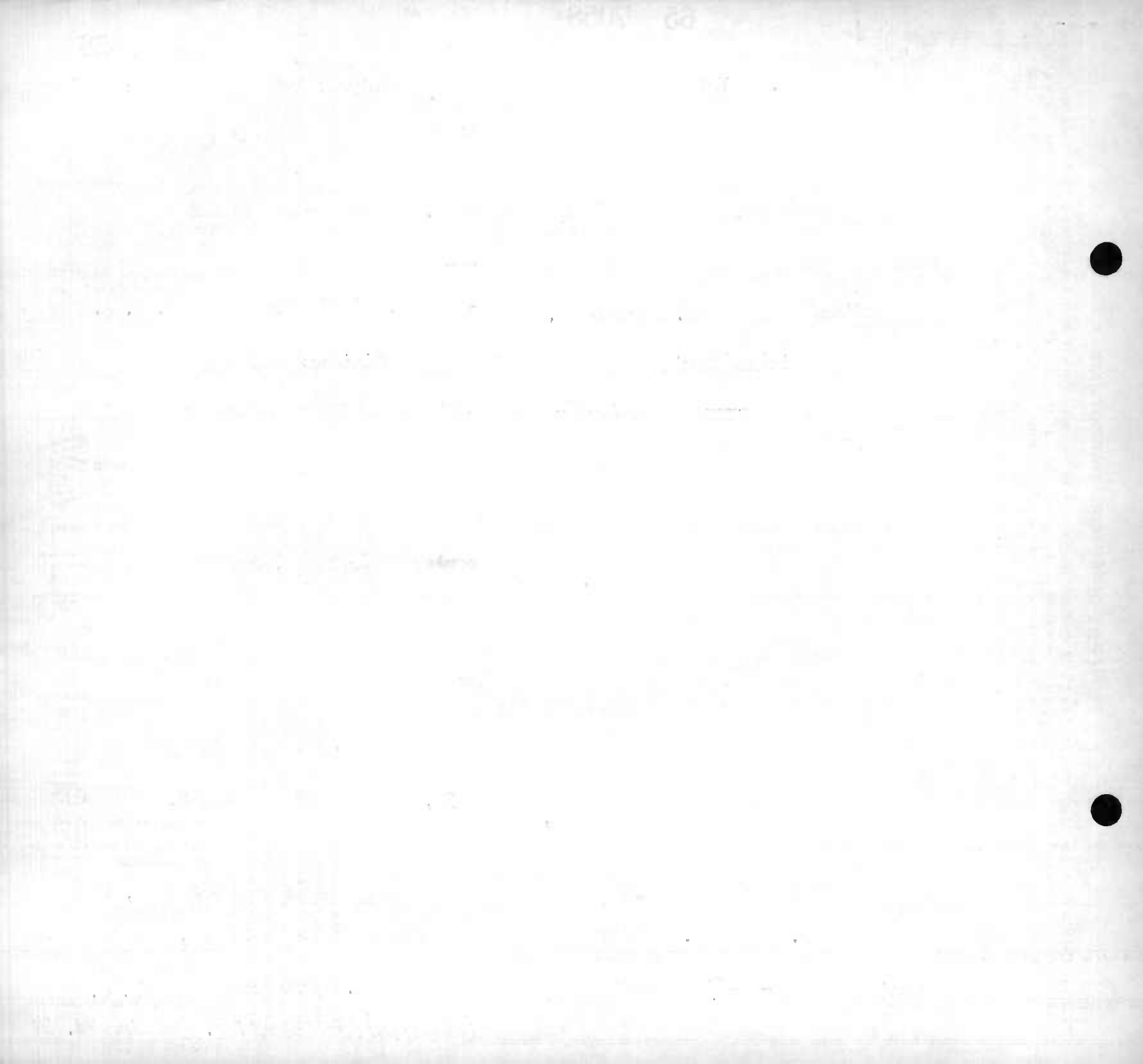
BIRTH NO. 65 7057		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7057	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thomas J. Connolly, 3RD.		2. DATE AND HOUR OF DEATH July 3, 1965 7:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL: 53-00 D. STREET ADDRESS (If rural, give location) 7534 Durwood Road #21222			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 3-4-27	9. AGE (In years last birthday) 38	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY Chauffeur		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas J. Connolly, Jr.		14. MOTHER'S MAIDEN NAME Edith Scott	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 217-20-3166		17. INFORMANT RECORDS: BCH: 4940 Eastern Avenue #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Delirium Tremens DUE TO Bronchopneumonia Diplococcus Pneumonia Pseudomonas (B) DUE TO (C) Status Post Renal Failure		INTERVAL BETWEEN ONSET AND DEATH 6-23-65	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 23, 19 65 to July 3, 19 65, that (I) (we) last saw the deceased alive on July 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. B. Zachary		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. J. B. Zachary		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) 2901 Taylor Ave. Ba. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR Charles S. Seiler		ADDRESS 6224 Eastern Ave Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

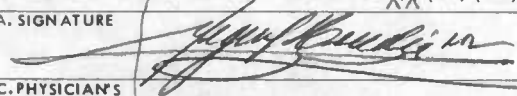
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

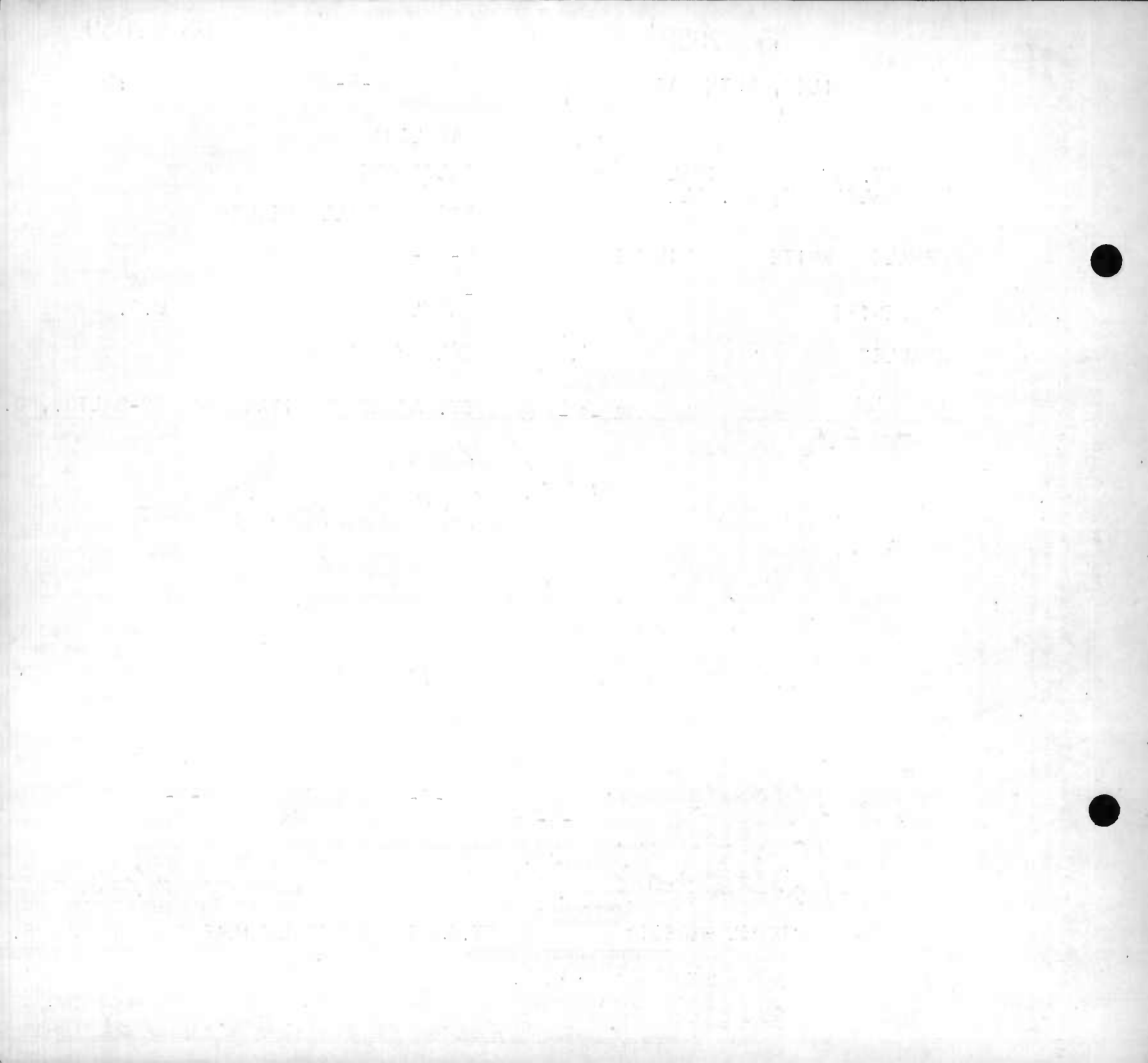
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. <i>D-150 65 7058</i>					CERTIFICATE OF DEATH					Registered No. <i>65 7058</i>				
1. NAME OF DECEASED (Type or Print) <i>John T. Devine</i>					2. DATE AND HOUR OF DEATH <i>July 2, 1965</i> <i>6:45</i> P. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland #21224</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-89</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
5. SEX <i>Male</i>					6. RACE <i>White</i>					7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Md. Drydock Co.</i>					8. DATE OF BIRTH <i>9-2-1890</i>				
										9. AGE (In years last birthday) <i>74</i>				
										11. BIRTHPLACE (State or foreign country) <i>Delaware, Wilmington</i>				
										12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>Michael Devine</i>					14. MOTHER'S MAIDEN NAME <i>Winifred Halloran</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>215-07-0289</i>					17. INFORMANT ADDRESS <i>RECORDS: BCH 4940 Eastern Avenue #21224</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Gram Negative Septicemia</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 Days</i>														
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Urinary Tract Infection</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 Days</i>														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Nodular Hyperplasia, Prostate</i> INTERVAL BETWEEN ONSET AND DEATH <i>?</i>														
19A. DATE OF OPERATION <i>2</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>Yes</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>June 30,</i> 19 <i>65</i> to <i>July 2,</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 2,</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>H. Rath</i>										23B. DATE SIGNED <i>July 2, 1965</i>				
23C. PHYSICIAN'S NAME (Type) <i>Dr. Howard K. Rathbun</i>										23D. ADDRESS <i>M.D. 4940 Eastern Avenue Baltimore, Maryland #24</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>7-6-65</i>					24C. NAME of CEMETERY or CREMATORY <i>Baltimore Cemetery</i>				
24D. LOCATION (City, town, or county) <i>E. North Avenue Balto. Md.</i>														
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>					25C. FUNERAL DIRECTOR ADDRESS <i>Lebanon S. Zeiler 901 S. Conkling St. #24</i>				



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 7059				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7059	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BILES, RUTH MAE				2. DATE AND HOUR OF DEATH 7-4-65 7:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-06			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL BALTIMORE, MD. 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 416 FONTHILL AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7-18-18 19	9. AGE (In years last birthday) 47 45	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME CHARLES				
14. MOTHER'S MAIDEN NAME ZOLA HARRISON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				
16. SOCIAL SECURITY NO. 218-42-5019			17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS-BALTO., MD.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 593X I Chronic Chronic Renal failure				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 7-3-1965 to 7-4-1965, that (X) (we) last saw the deceased alive on 7-4-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  MIGUEL HEREDIA				23B. DATE SIGNED 7/5/65		23C. PHYSICIAN'S NAME (Type) M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-65		24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank W. Seitz		ADDRESS 814 W 36th St	



FUNERAL DIRECTOR: IMPORTANT

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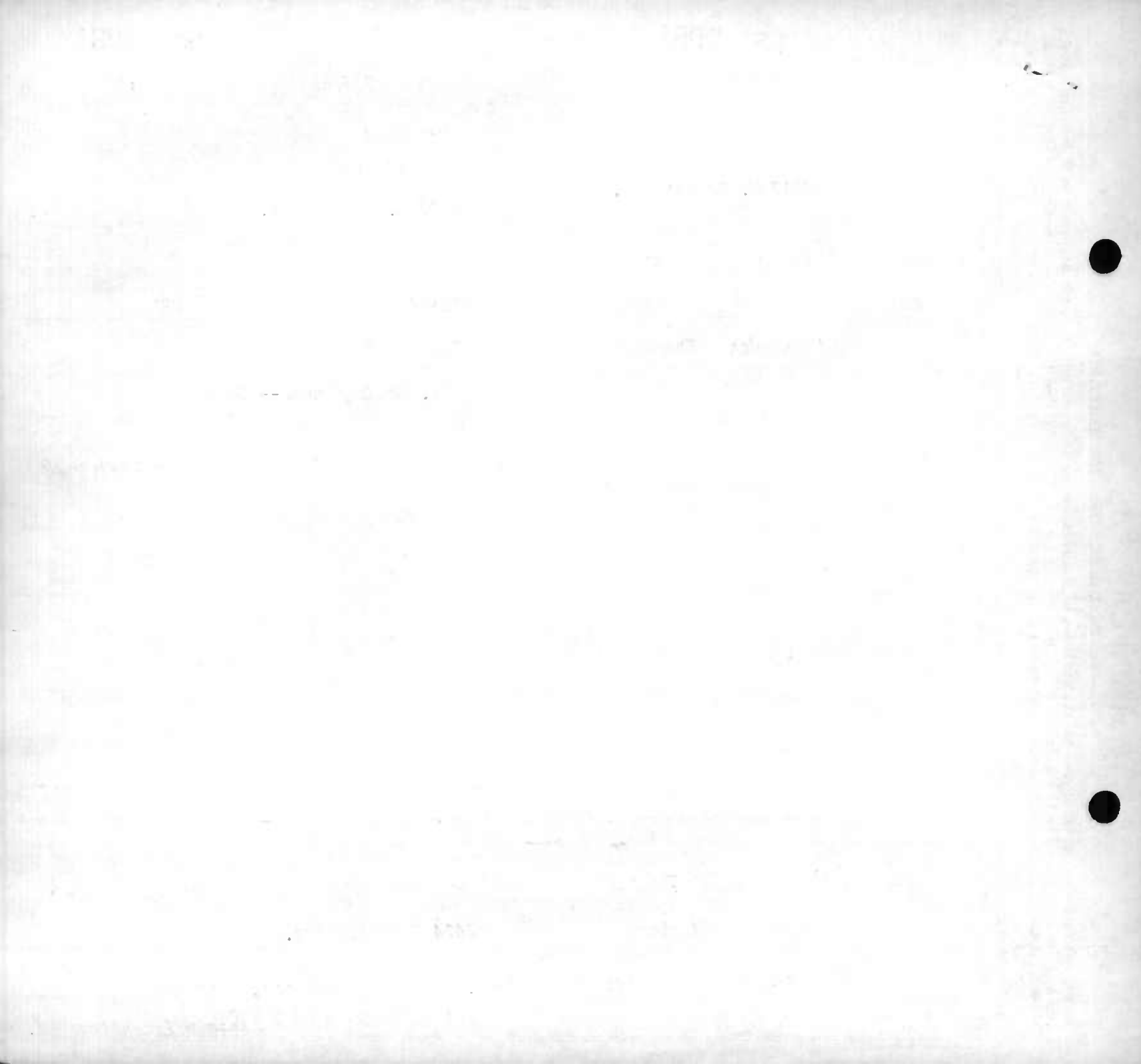
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7060	
BIRTH NO. 65 7060				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Carolyn Mae Carter				2. DATE AND HOUR OF DEATH 7/6/65 7:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3919 Park Heights Ave #15	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 7/12/78	9. AGE (In years last birthday) 27 86	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Veteran's Administration Washington		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Wilbur E. Carter			14. MOTHER'S MAIDEN NAME Elizabeth Soper		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Hosp. Rec.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Aortic - ? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Obstructive Pulmonary Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-5 19 65 to 7-6 19 65 , that (I) (we) last saw the deceased alive on 7-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (advised) view the body after death.					
23A. SIGNATURE Philip A. Insley MD				23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) Philip A. Insley				23D. ADDRESS University Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Robert E. Fairbank		25D. ADDRESS 4611 Park Heights Ave.	

10345 451 741045

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

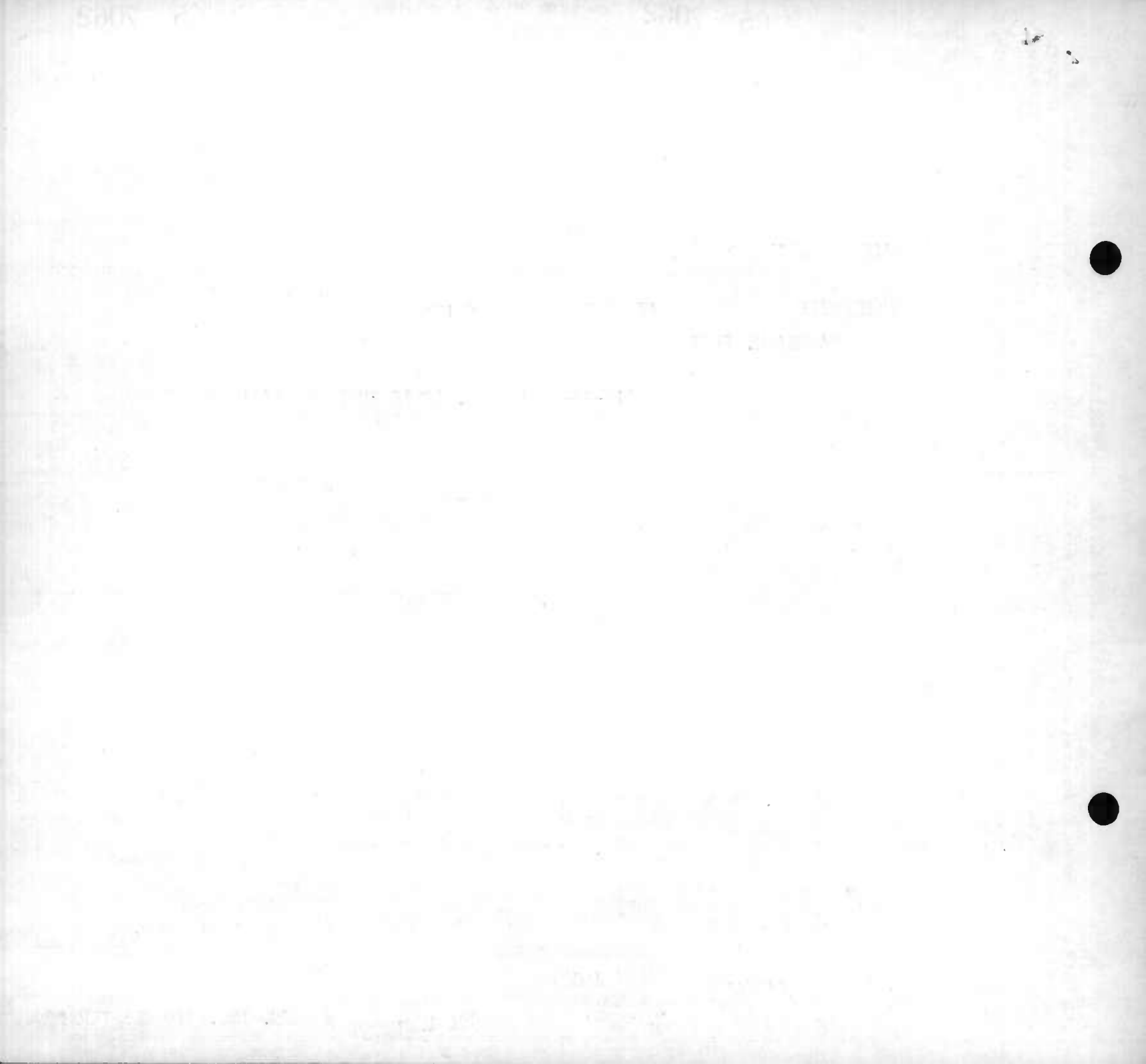
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7061	
BIRTH NO. 65 7061		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 7/4/65 3:30 PM	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JACOB FRUMAN		2. DATE AND HOUR OF DEATH 7/4/65 3:30 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 28-31		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 00 4217 W. Rogers Ave.		D. STREET ADDRESS (If rural, give location) 4217 W. Rogers Ave.		12. CITIZEN OF WHAT COUNTRY? USA	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-26-1896	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat		10B. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Alexander Fruman		14. MOTHER'S MAIDEN NAME Ida ?		17. INFORMANT Mrs. Betty Fruman-- Same	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORDIARY OCCLUSION		CAUSE OF DEATH (A) DUE TO CORDIARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO CEREBRAL Phlebothrombosis		8 yrs	
		(C) GENERALIZED ARTERIOSCLEROSIS		10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. EPILEPSY, JACKSONIAN				6 yrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 8 1955 to July 4 1965 , that (I) (we) last saw the deceased alive on JANUARY 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Randolph H. Spitzberg				23B. DATE SIGNED July 5, 1965	
23C. PHYSICIAN'S NAME (Type) Randolph Spitzberg		23D. ADDRESS M.D. 6024 Berkeley Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/65		24C. NAME OF CEMETERY or CREMATORY Aitz Chaim Cong.	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC			
25D. ADDRESS 6040 Reisterstown Rd.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

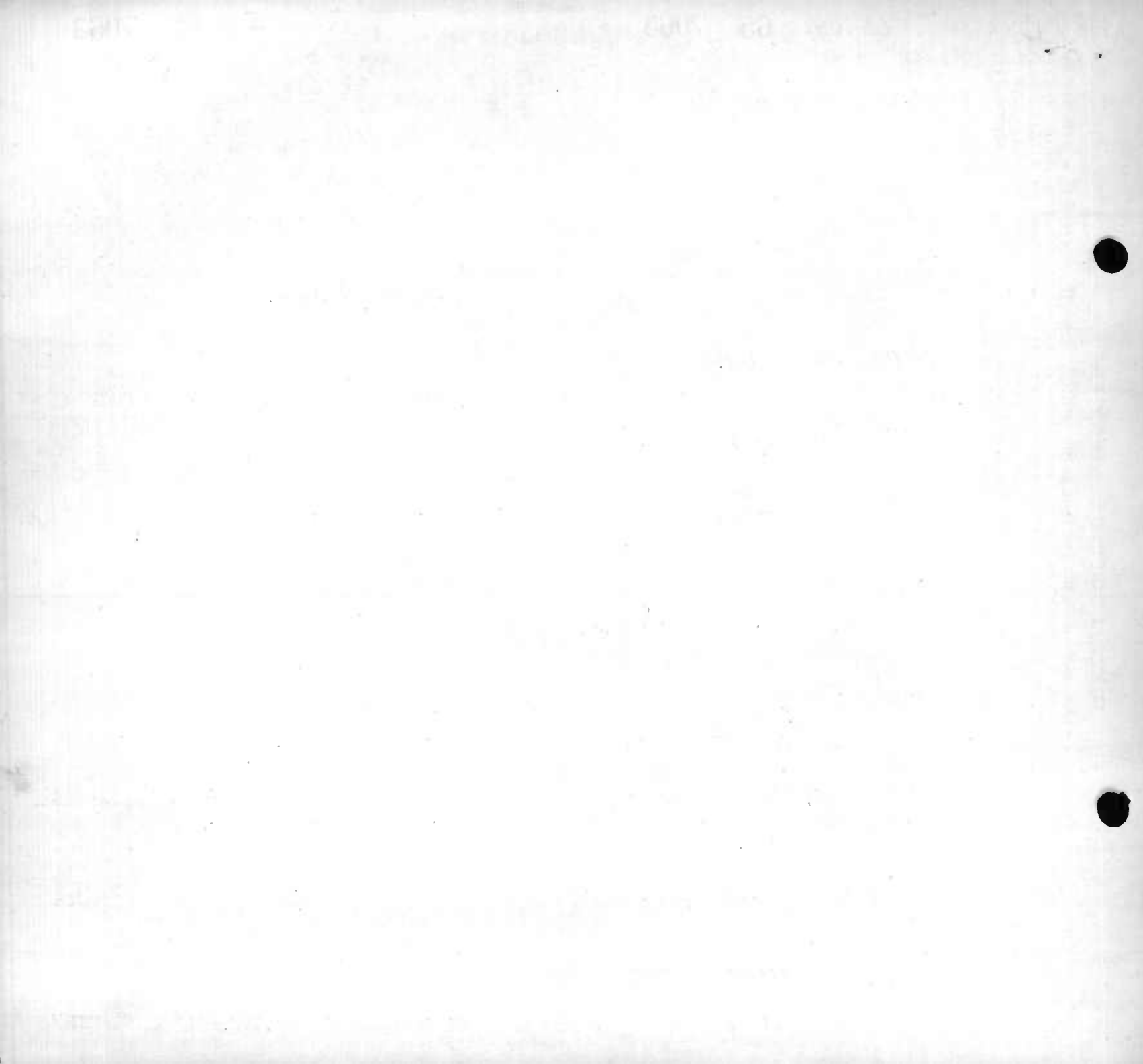
BIRTH NO.		65 7062		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7062	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				RUBIN, HELEN			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore, Inc. 42				(If not in hospital or institution, give street address or location)			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				A. STATE Md. 53-00			
B. COUNTY				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Baltimore 8				D. STREET ADDRESS (If rural, give location)			
3101 Marnat Rd.				5. SEX FEMALE			
6. RACE WHITE				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			
Married				8. DATE OF BIRTH			
9-1-14				9. AGE (In years lost birthday)			
50				If Under 1 Yr. Months Days			
If Under 24 Hrs. Hours Min.				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY			
AT HOME				11. BIRTHPLACE (State or foreign country)			
BALTIMORE MARYLAND				12. CITIZEN OF WHAT COUNTRY?			
USA				13. FATHER'S NAME			
SAMUEL W. FEIT				14. MOTHER'S MAIDEN NAME			
ROSE FARBER				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
NO				16. SOCIAL SECURITY NO.			
212-03-0621				17. INFORMANT			
MR. LOUIS RUBIN				ADDRESS			
3101 MARNAT ROAD				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				A. DUE TO			
II				B. DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				C. DUE TO			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from 7-6 1965 to 7-6 1965, that (I) (we) last saw the deceased alive on 7-6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
R. J. DUREZA				7-6-65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
R. J. DUREZA				Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
BURIAL				7/7/65			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
BETH JACOB				FINKSBURG MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUL 7 1965				R. J. DUREZA			
25C. FUNERAL DIRECTOR				ADDRESS			
SOL LEVINSON				6 BROS. INC. 6010 REISTERSTOWN R			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

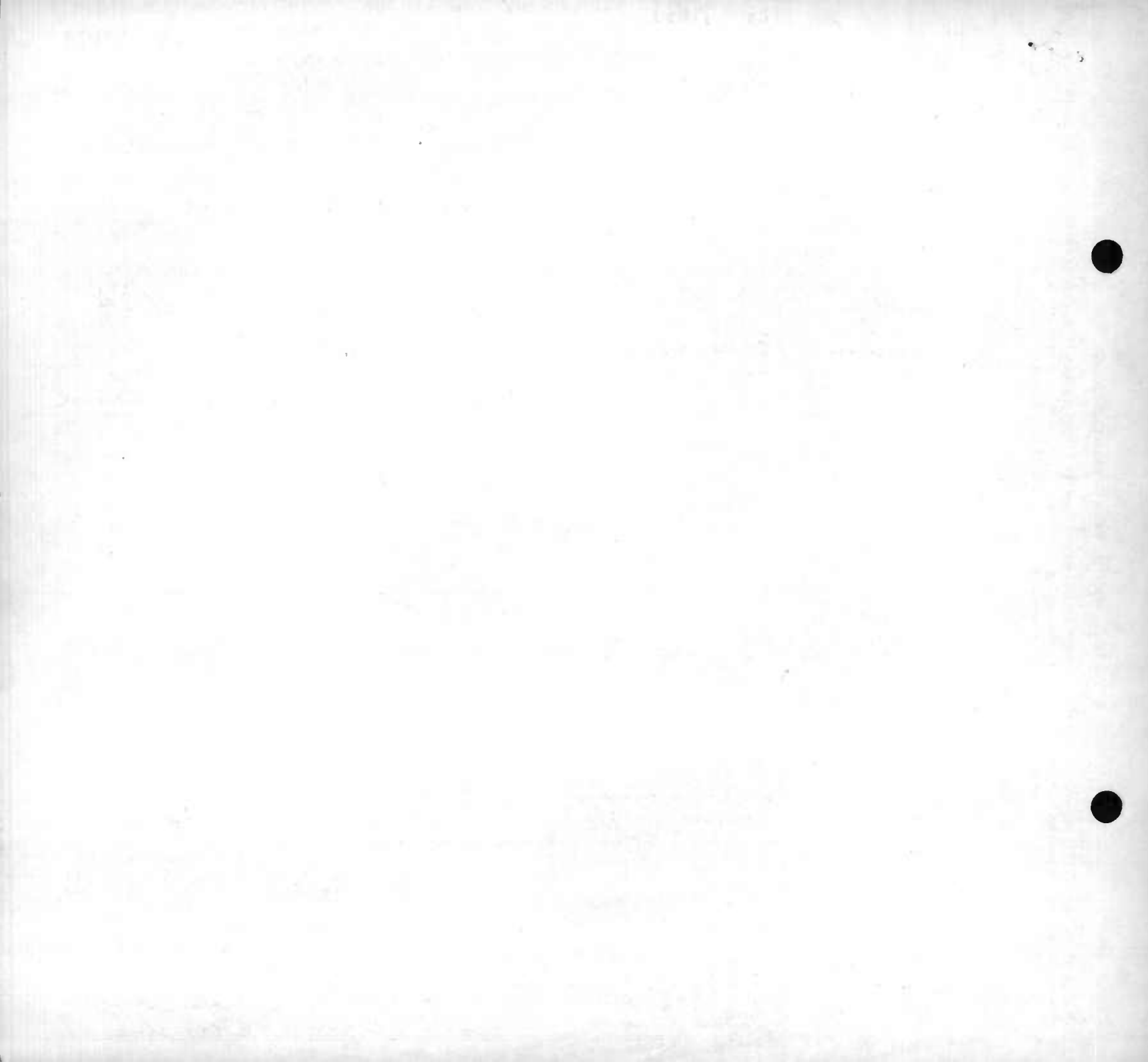
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65-1640965		7063		CERTIFICATE OF DEATH			Registered No. 65 7063		
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Baby Girl Dashoff					2. DATE AND HOUR OF DEATH 7-5-65 4:05 am				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 53-00				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207				
D. STREET ADDRESS (If rural, give location) 6805 Southern Cross Court									
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Infant		8. DATE OF BIRTH 7/5/65		9. AGE (In years last birthday) If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 3 30	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MARVIN DASHOFF					14. MOTHER'S MAIDEN NAME ROSALIE GORDON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MR. MARVIN DASHOFF 6805 SOUTHERN CROSS COURT					
18. 773.5 I CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Respiratory distress syndrome DUE TO 3 1/2 hrs.				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Prematurity DUE TO 3 1/2 hrs.					
				(C) —					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none									
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) —		21C. WHERE DID INJURY OCCUR? —		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —					
22. I certify that (1) (this hospital) attended the deceased from 12:30 am 7-5 19 65 to 4:05 am 7-5 19 65, that (1) (we) last saw the deceased alive on 4:05 am 7-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John H. Johnson					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-5-65		
23C. PHYSICIAN'S NAME (Type) JOHN D. JOHNSON					23D. ADDRESS The Johns Hopkins Hospital Baltimore, Md. 21205				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/65		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMINO		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			25B. NAME OF REGISTRAR Robert E. Farkas			25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7064		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7064	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Miss Helen Freedman		2. DATE AND HOUR OF DEATH 7/3/65 3:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 28-41		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Baltimore, Inc		D. STREET ADDRESS (If rural, give location) 4417 Belknap Ave Belview			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec		10B. KIND OF BUSINESS OR INDUSTRY Office		11. BIRTHPLACE (State or foreign country) Balt, Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sam Freedman		14. MOTHER'S MAIDEN NAME Florence ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Andrew Freeman - Home	
18. 153-3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Multiple atherosclerosis 2) Ca of sigmoid		CAUSE OF DEATH (A) DUE TO Pulmonary embolism (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 60 min	
19A. DATE OF OPERATION 1 June 30, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstructive duodenal Ca of sigmoid		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/29 1965 to 7/3 1965, that (I) (we) last saw the deceased alive on 7/3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Schum		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/65	
23C. PHYSICIAN'S NAME (Typo)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/65		24C. NAME OF CEMETERY or CREMATORY Heaven Friendship Balto Md.	
24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Sol Ferraro Bros Inc			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7065	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 7065</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) SARAH D. MAZUR</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 7/5/65 1:30 A. M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>00 4401 Forest Park Ave.</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY 28-03</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 4401 Forest Park Ave.</p>		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Lith		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Hyman Baer Cohn			14. MOTHER'S MAIDEN NAME Etta ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Mildred Marcus-- 4401 Forest Park Ave.		
<p>18. 332X I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHOPNEUMONIA</p>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from MAY 1962 to JULY 5, 1965, that (I) (we) last saw the deceased alive on JULY 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.</p>					
23A. SIGNATURE Marvin Goldstein				23B. DATE SIGNED JULY 5, 1965	
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN				23D. ADDRESS 5334 Liberty Heights Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/6/65	24C. NAME of CEMETERY or CREMATORY Anshe Emunah Cong.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd.	

FUNERAL DIRECTOR: IMPORTANT

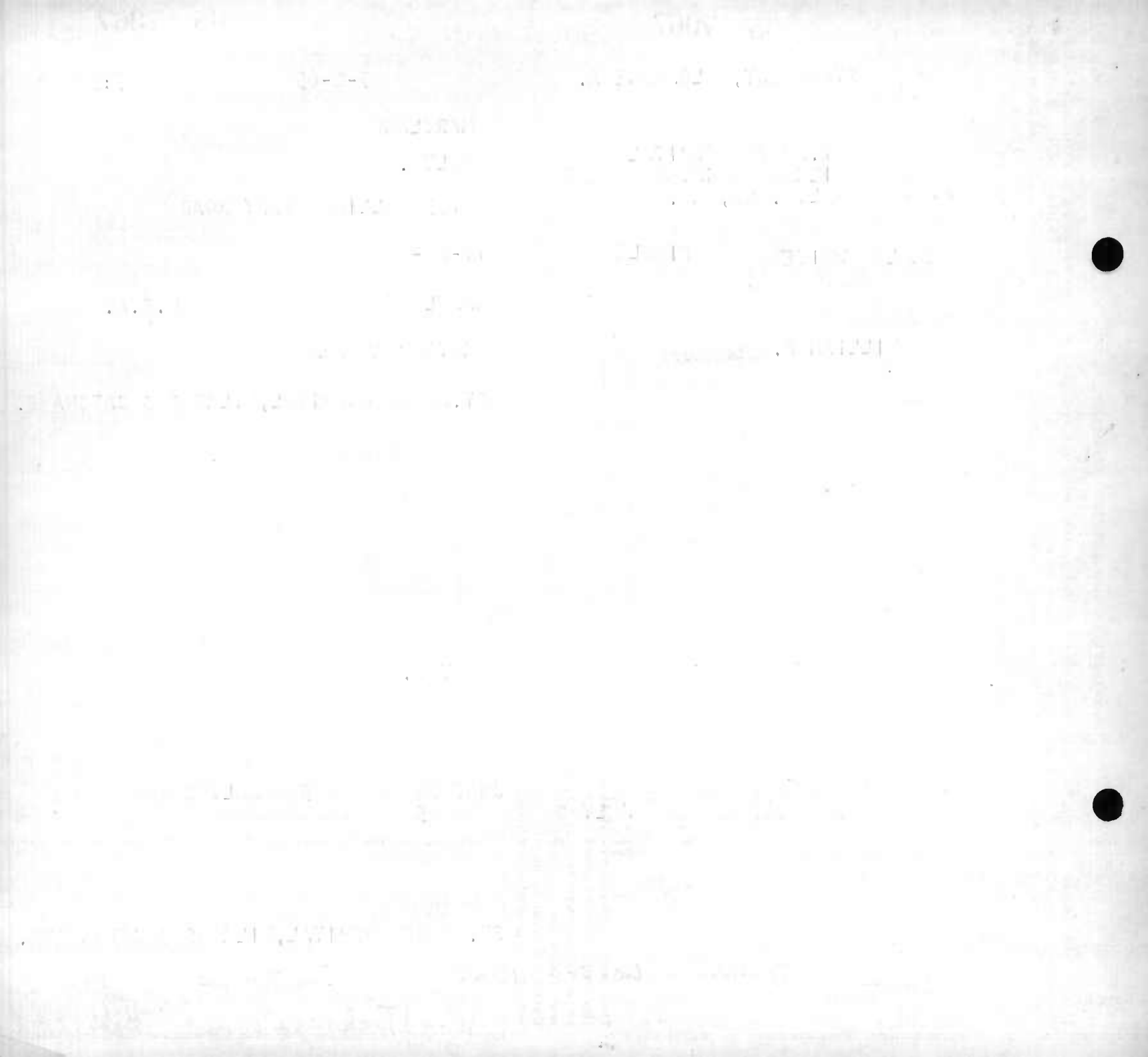
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BIRTH NO. 1-355 65 7066		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7066	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ida Goodman</i>		2. DATE AND HOUR OF DEATH <i>July 5, 1965 6:40 A. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>53-00</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Jewish Conv. Home</i> <i>4601 Paine Place Road</i>		D. STREET ADDRESS (If rural, give location) <i>3302 Lightfoot Drive</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Jan 10, 1884</i>	9. AGE (In years last birthday) <i>81</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Latvia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Abraham Cohen</i>		14. MOTHER'S MAIDEN NAME <i>Fraida ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Gilbert Rudman - 3302 Lightfoot Drive</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>490X I</i>		CAUSE OF DEATH (A) <i>LOBAR PNEUMONIA, LOWER RT.</i> (B) <i>DUE TO</i> (C) <i>DUE TO</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CEREBRAL THROMBOSIS</i> <i>ARTERIOSCLEROSIS, GENERALIZED</i>		<i>3 YEARS</i> <i>11 YEARS</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 2, 1965</i> to <i>July 5, 1965</i> , that (I) was last saw the deceased alive on <i>July 4, 1965</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE <i>Gilbert E. Rudman</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>7/5/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>GILBERT E. RUDMAN</i> M.D.				23D. ADDRESS <i>2517 W. BALTIMORE ST.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 6/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>B'nai B'rach</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Sal Hinson & Son - 6000 Reut. Rd</i>		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

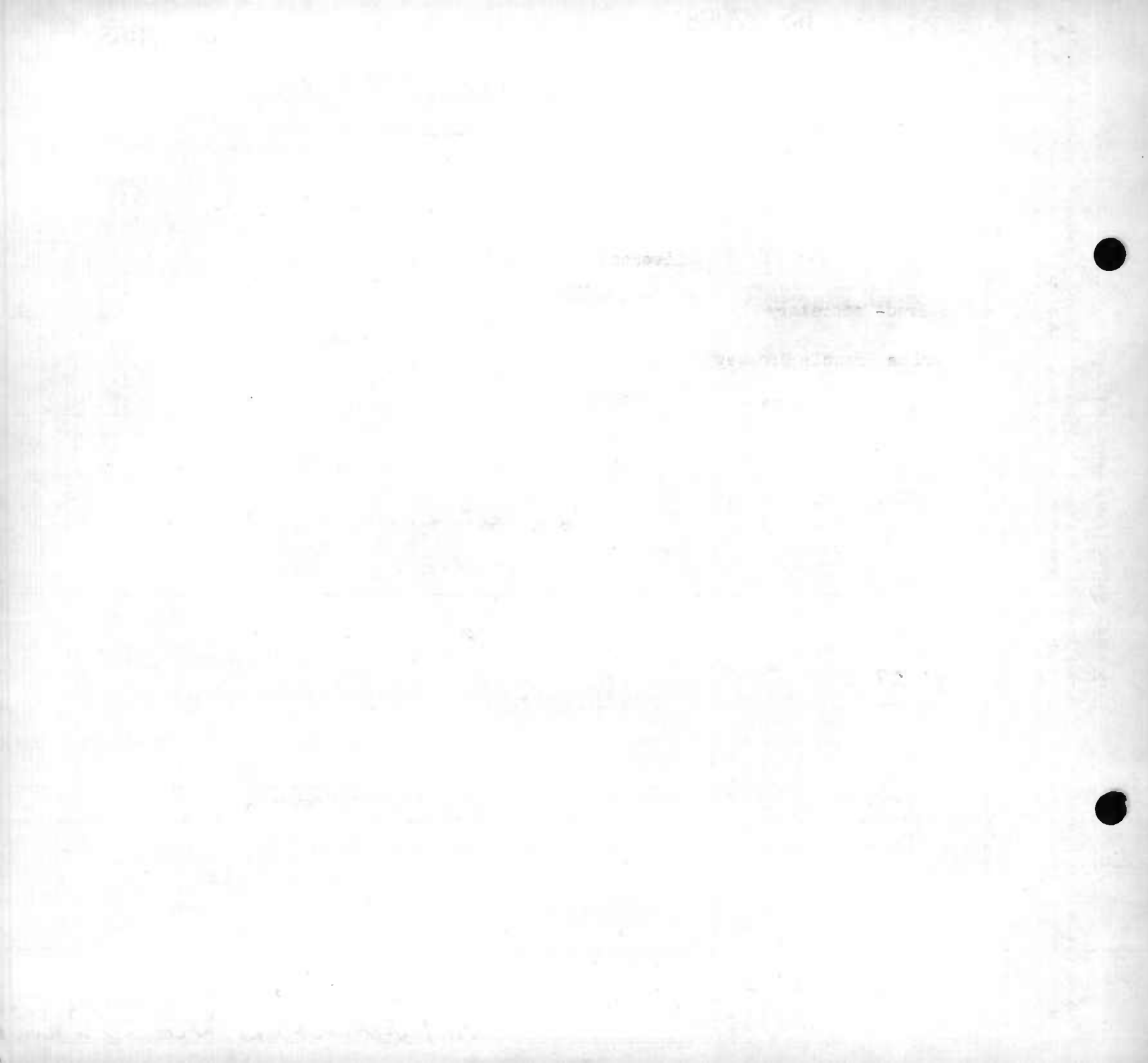
BIRTH NO. 65 7067				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7067	
1. NAME OF DECEASED (Type or Print) STANSBURY, FLORENCE A.				2. DATE AND HOUR OF DEATH 7-2-65 7:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 4173 HOLLINS FERRY ROAD					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11-26-90	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. Stansbury				14. MOTHER'S MAIDEN NAME KATE PUMPHREY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.				
18. 491 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Bilateral Bronchopneumonia				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO			
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JUNE 24 19 65 to JULY 2 19 65 , that (I) (we) last saw the deceased alive on JULY 2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Edmund P. Beltran				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/5/65		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Wm J. Tucker & Sons		ADDRESS Balt 17 Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7068		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7068	
M.E. CASE NO.		CERTIFICATE OF DEATH		1	
1. NAME OF DECEASED (Type or Print) PICKERING, MARGARET Ellen		2. DATE AND HOUR OF DEATH 7/3/65 17:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Md. GENERAL HOSPITAL BALTO., Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 18 md. D. STREET ADDRESS (If rural, give location) 1925 St. Paul St.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 4/19/95	9. AGE (In years lost birthday) 70	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - secretary		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Charles Francis Brookey		14. MOTHER'S MAIDEN NAME Ellen MARY CHAMBERS		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO.		17. INFORMANT IDENTIFICATION RECORD OF HOSP.	
18. 585X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA, MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) gram negative bacteremic shock (B) bacteremia (C) peritonitis		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6/28/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLECYSTITIS		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/28 1965 to 7/3 1965, that (I) (we) last saw the deceased alive on 7/3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Fairbank		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-3-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/1965		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION Woodlawn, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 7 1965		24F. NAME OF REGISTRAR Robert E. Fairbank	
24G. FUNERAL DIRECTOR Wm. J. Jackson & Sons		24H. ADDRESS Baltimore, Md. 21217			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7069				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7069	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH		5 A. M.	
1. NAME OF DECEASED (Type or Print) Frank Howard Ware				2. DATE AND HOUR OF DEATH July 5, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4212 Loch Raven Boulevard Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male				6. RACE White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				8. DATE OF BIRTH 2/12/1892			
9. AGE (In years lost birthday) 73				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Cashier			
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Frank Ware				14. MOTHER'S MAIDEN NAME Ida Wagner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I				16. SOCIAL SECURITY NO. 219-22-0324			
17. INFORMANT Mrs. Lucy Ware				ADDRESS 4212 Loch Raven Boulevard Baltimore, Maryland 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) MALABSORPTION SYNDROME (B) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE (C)			
INTERVAL BETWEEN ONSET AND DEATH 5 YEARS 8 YEARS 6 YEARS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC DIARRHEA							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from JAN 1957 to JULY 5, 1965, that (I) (we) lost saw the deceased alive on JULY 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Arthur Karfgin				23B. DATE SIGNED 7/6/65			
23C. PHYSICIAN'S NAME (Type) ARTHUR KARFGIN				23D. ADDRESS 1532 HAVENWOOD ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/8/1965			
24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery				24D. LOCATION (City, town, or county) Pikesville, Maryland (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965				25B. NAME OF REGISTRAR Robert E. Fairbank			
25C. FUNERAL DIRECTOR Wm. J. Fairbank				ADDRESS Baltimore, Md. 17			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 7070</u>				
BIRTH NO. <u>165 7070</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Marie JACQUELINE NEWTON</u>					2. DATE AND HOUR OF DEATH <u>7-5-65</u> <u>6:05</u> P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>VIRGINIA</u> B. COUNTY <u>V-43</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>THE JOHNS HOPKINS HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>HAMPTON</u>				
					D. STREET ADDRESS (If rural, give location) <u>113 BRISTOL COURT</u>				
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>12-28-62</u>	9. AGE (In years last birthday) <u>2YRS</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Newport News, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>PETER CHARLES NEWTON</u>					14. MOTHER'S MAIDEN NAME <u>RUTH THOMAS</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Johns Hopkins Hospital Records</u>					ADDRESS
18. <u>2043 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>SEPSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>					19. <u>II</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ACUTE LEUKEMIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) <u>NONE</u>		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (XXXXXX) attended the deceased from <u>JUNE 29,</u> 19 <u>65</u> to <u>JULY 5,</u> 19 <u>65</u> , that (X) (we) lost saw the deceased alive on <u>JULY 5,</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) (XXX) view the body after death.									
23A. SIGNATURE <u>Robert S. Thompson</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-5-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>ROBERT S. THOMPSON</u> M.D.					23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>7/7/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Parklawn Memorial Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Hampton, Virginia</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Ficknew</u> ADDRESS <u>Balt. Md. 21217 North Pa. ave.</u>					

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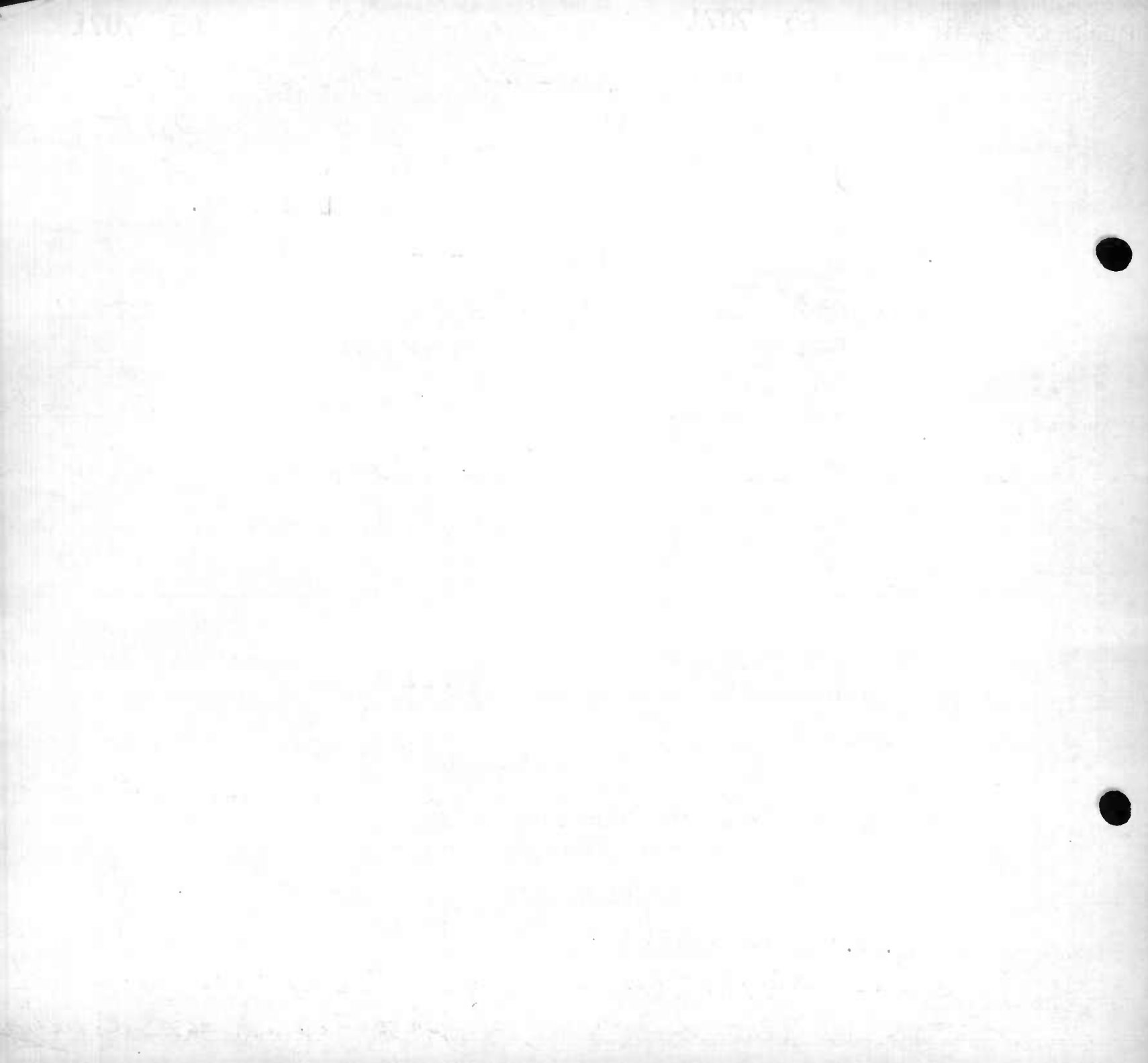
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7071		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7071	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MANDRAS, Angelo John		2. DATE AND HOUR OF DEATH 7-6-65 5:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 7	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		D. STREET ADDRESS (If rural, give location) 1518 INGLESIDE AVE.		E. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-24-23	9. AGE (In years lost birthday) 41	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY GAMERMAN'S		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME THOMAS MANDRAS		14. MOTHER'S MAIDEN NAME ANNA TANDA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.		17. INFORMANT IRENE E. MANDRAS	
18. 4/6 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Bacterial Endocarditis DUE TO (B) Rheumatic heart disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 7-2-1965 to 7-6-65 19 that (I) (we) last saw the deceased alive on 7-6-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Patrick Caulfield M.D. 23B. DATE SIGNED 7-6-65	
23C. PHYSICIAN'S NAME (Type) DR. J. PATRICK CAULFIELD M.D.		23D. ADDRESS Johns Hopkins Hospital		23E. FUNERAL DIRECTOR Joseph X. Zornum	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 9, 1965		24C. NAME of CEMETERY or CREMATORY OAKLAWN CEM	
24D. LOCATION (City, town, or County) (State) EASTERN AVE Balto Md		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. ADDRESS 263 S. Conkling		25D. ADDRESS 263 S. Conkling		25E. ADDRESS 263 S. Conkling	



1
S-335

65 7072

BALTIMORE CITY HEALTH DEPARTMENT

65 7072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL STATEN

2. DATE AND HOUR PRONOUNCED DEAD

7-5-65

1:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2840 Westwood Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

May 27 - 1955

9. AGE (In years
last birthday)

10

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Child

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James Staton

14. MOTHER'S MAIDEN NAME

Nancy Herring

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Nancy Staton

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic pyelonephritis
DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

WERNER U. SPIEZ, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7-5-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-1965

23C. NAME OF CEMETERY or CREMATORY

St. Calvary Cmt

23D. LOCATION

Brooklyn Md

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Chas. C. Wilson, 1000 Brantley St

ADDRESS

WALTER B. BROWN

My dear Mr. Brown:

I have just received your letter of the 10th inst. and am glad to hear from you. I am well and hope this finds you the same.

I am, Sir, very respectfully,
 Yours truly,
 W. B. Brown

W. B. BROWN

W. B. BROWN

FUNERAL DIRECTOR: IMPORTANT

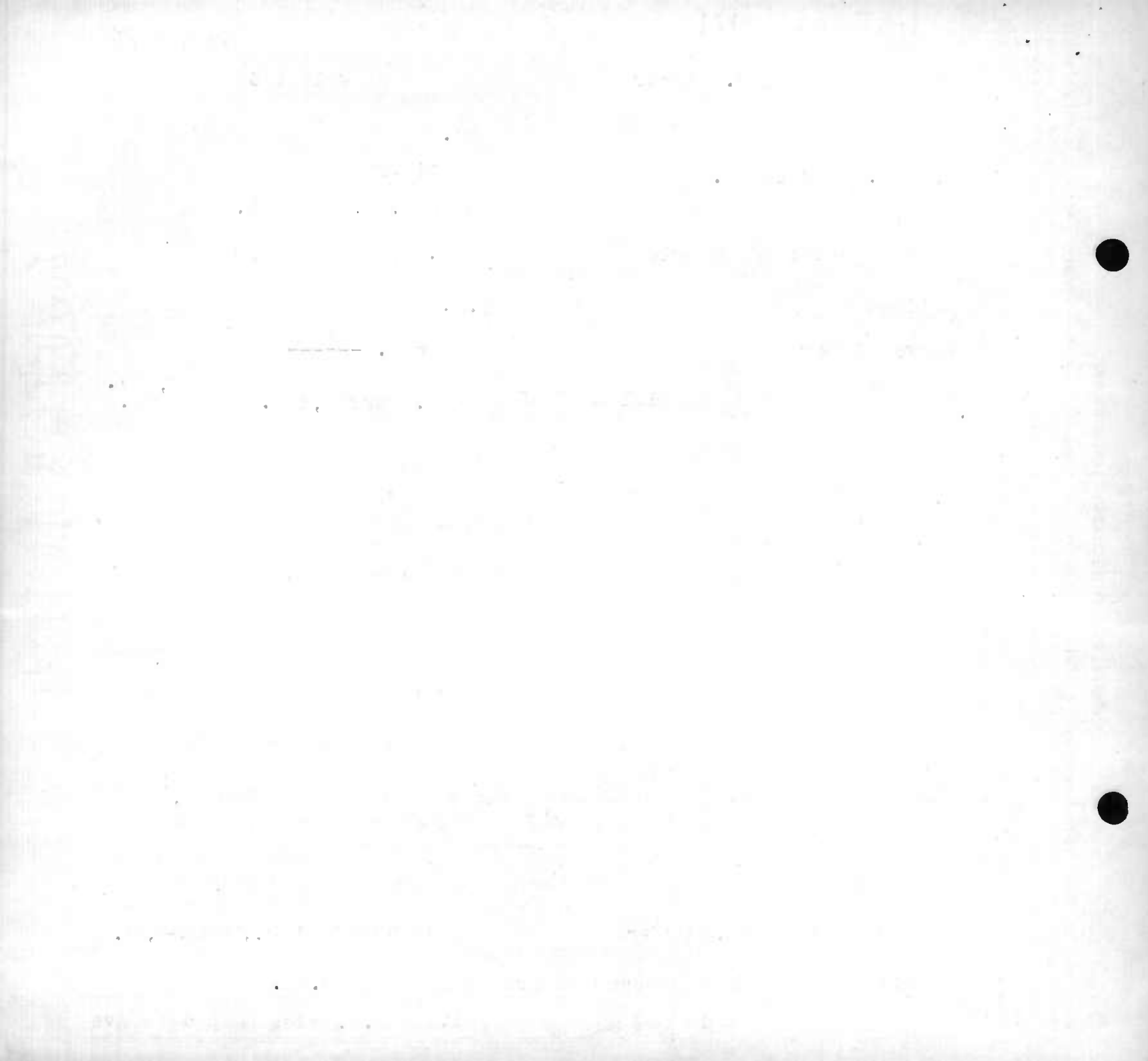
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7073		CITY HEALTH DEPARTMENT		Registered No. 65 7073	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
Louis Holloman			2. DATE AND HOUR OF DEATH		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
Johns Hopkins Hospital (If not in hospital or institution, give street address or location) Baltimore 5, Maryland			A. STATE B. COUNTY MARYLAND		
5. SEX			6. RACE		
m			N		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
married			5-15-08		
9. AGE (In years lost birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
53			Civil Service		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
North Carolina			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
XXX CHARLES			SIDNEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no					
17. INFORMANT			ADDRESS		
Alice Holloman					
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			5 minutes		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Probable myocardial infarction		
ANTECEDENT CAUSES			(B) generalized arteriosclerotic disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 24 19 65 to July 6 19 65, that (I) (we) last saw the deceased alive on July 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William B. Cutts				7/6/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
William B. Cutts				Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7-10-1965		Arbutus Ave	
24D. LOCATION (City, town, or county)		24E. NAME of REGISTRAR		24F. FUNERAL DIRECTOR	
Baltimore		Robert E. Taylor		Shoy Wilson Wood Brantley Jr	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME of REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 7 1965		Robert E. Taylor		Shoy Wilson Wood Brantley Jr	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7074		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Paul B. Misner		2. DATE AND HOUR OF DEATH July 1/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2905 N. Charles St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2905 N. Charles St.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept. 27/94
9. AGE (In years last birthday) 70		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Misner		14. MOTHER'S MAIDEN NAME Helen B. -----	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 191 28 7125	
17. INFORMANT Gaithersburg, Md.		18. CAUSE OF DEATH Coronary Occlusion	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		20. INTERVAL BETWEEN ONSET AND DEATH Immediate	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 25 yrs + 5 19 June 23, 1965 to June 23, 1965 , that (I) (we) last saw the deceased alive on June 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Walter A. Baetjer		23B. DATE SIGNED 7/2/65	
23C. PHYSICIAN'S NAME (Type) Walter A. Baetjer		23D. ADDRESS 1010 Saint Paul St., Balto.-2, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/2/65	
24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Faley, M.D.	
25C. FUNERAL DIRECTOR Witzke F.D.		25D. ADDRESS 4101 Edmondson Ave	



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		65-7075	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
		Virginia M. Sebold VIRGINIA M. SEBOLD Sebold		7-4-65 4:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
ST. AGNES HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3211 Stafford Street 29			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Female	White	Widow	May 15/1911	54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
H.W.				Balto. Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Harry Inemer			Anna Kuhlman		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		216 03 3751		Mrs. Virginia Barbour, 336 Stonecastle Rd, Reisterstown, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
E 903.0 I		(A) Compression of brain subdural hematoma			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cirrhosis of liver			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	Yes		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		3211 Stafford Street 20-06	
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
7 2 '65 ?		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Fell in yard of home	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		7-5-65	
WERNER U. SPITZ, M.D.		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial	7/7/65	Loudon Park		Balto. 29, Md	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUL 7 1965		Robert E. Taylor, M.D.		Witzke F.D. 4101 Edmondson Ave.	

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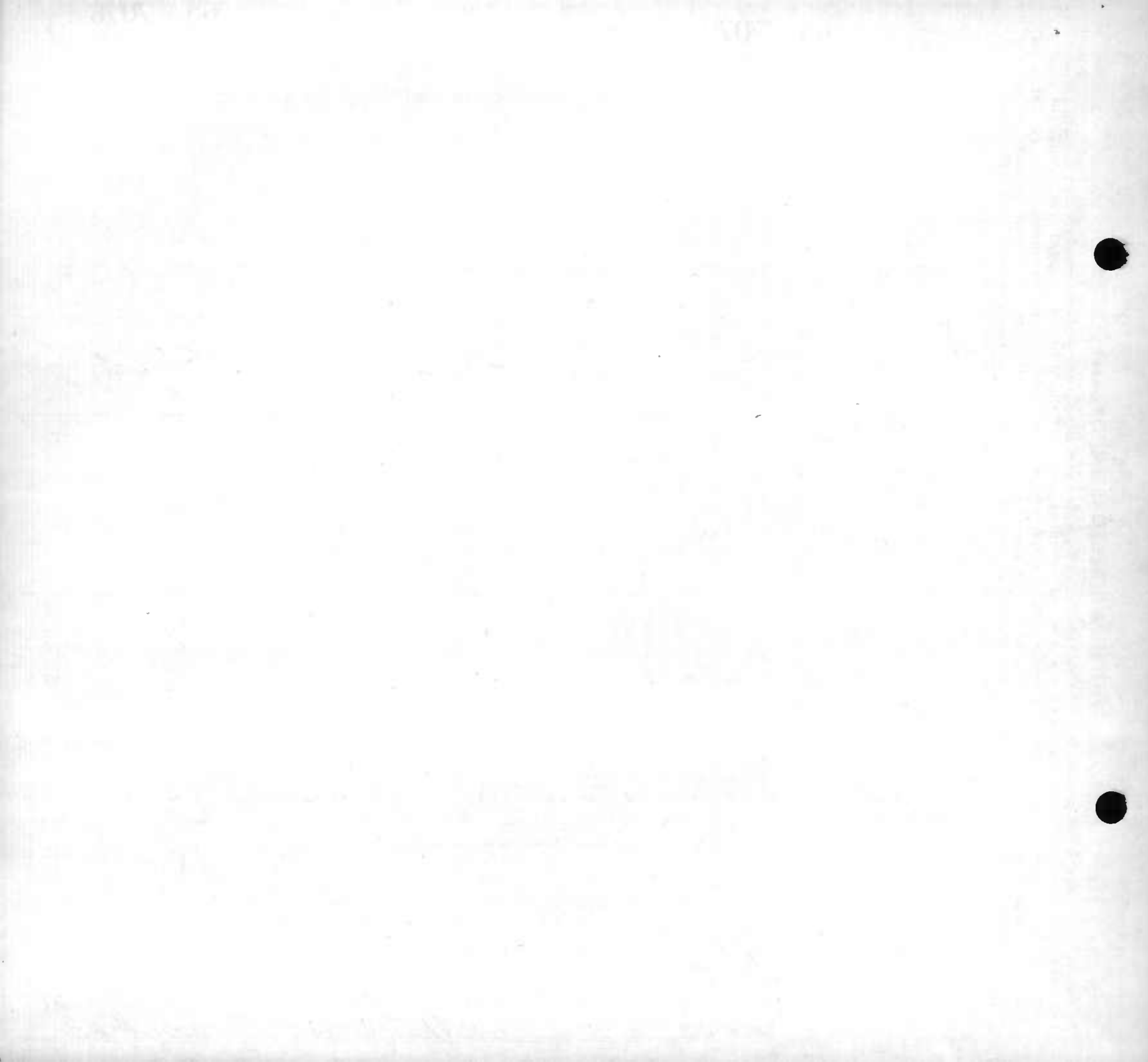
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

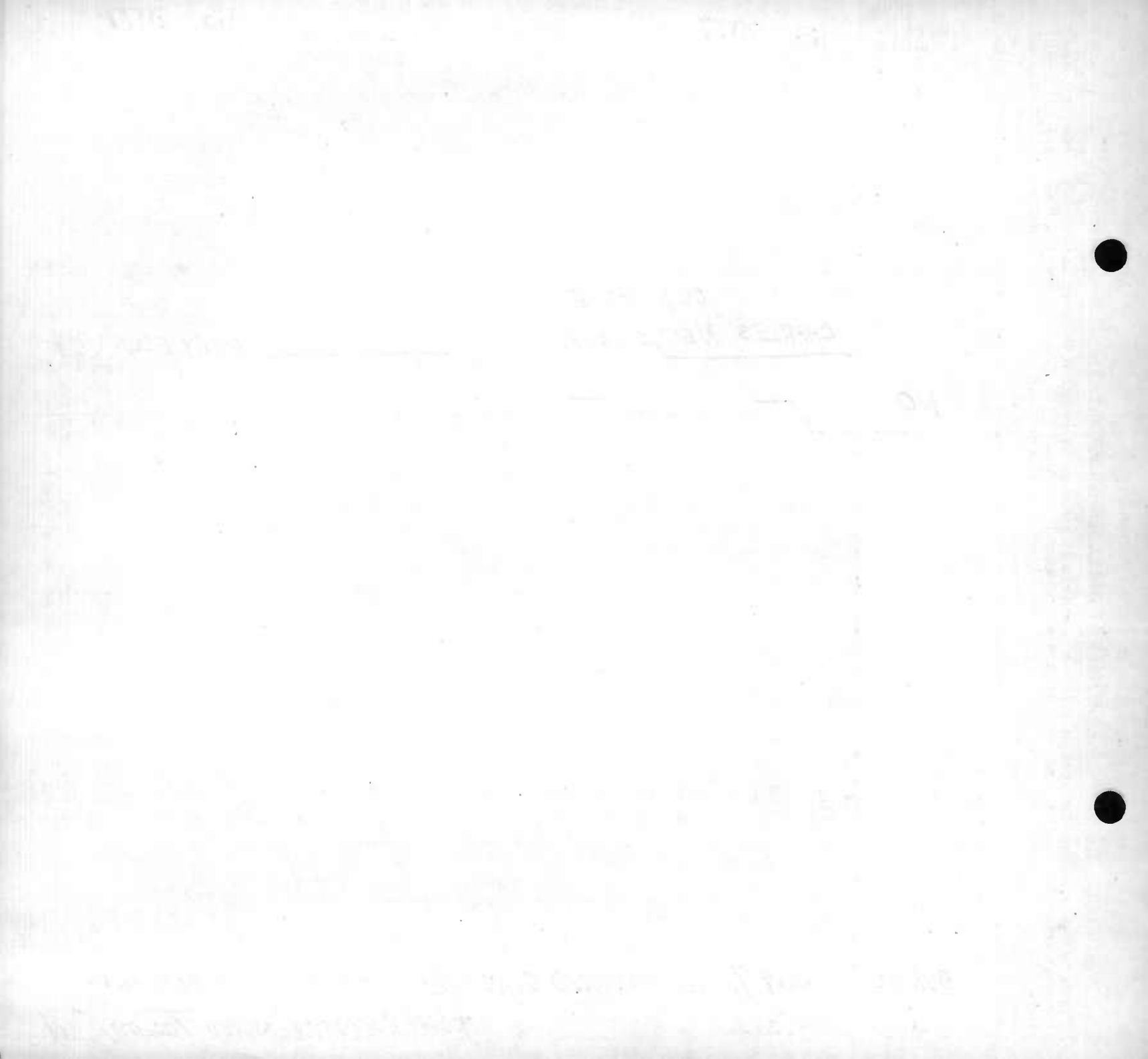
BIRTH NO. 65 7076		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7076	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HELEN G. SCHAFER		2. DATE AND HOUR OF DEATH July 5, 1965 2:00 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTIMORE, MC BELVEDERE AVE & GREENSPRING BALTIMORE, MARYLAND		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) THE HOUSE IN THE PINES - BELVED.			
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/24/02	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME Reed T. Goe		14. MOTHER'S MAIDEN NAME Emma Thompson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Dr. Richard W. Schaffer	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH DUE TO BLEEDING PEPTIC ULCER ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-29-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding peptic ulcer		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 29 1965 to July 5, 1965 1965, that (I) (we) last saw the deceased alive on July 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hawthorne N. Banez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input type="checkbox"/>		23B. DATE SIGNED 7-5-65	
23C. PHYSICIAN'S NAME (Type) HAWTHORNE N. BANEZ		23D. ADDRESS SINAI HOSP. OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/8/65		24C. NAME OF CEMETERY or CREMATORY Weston W. Va.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR W. F. F. 4101 Edmondson			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7077		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 7077	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) WILHELMINA PALMER		2. DATE AND HOUR OF DEATH 7-4-65 6:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN WILSON POINT D. STREET ADDRESS (If rural, give location) 53-00 1706 WILSON PT. ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-19-84	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES NEUNINGER NOT KNOWN			
14. MOTHER'S MAIDEN NAME NOT KNOWN MARY ELLA (?)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. —		17. INFORMANT HARRY PALMER 1706 WILSON PT. RD. BALTIMORE 20			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. MIDDLE CEREBRAL ARTERY THROMBOSIS 22 DAYS		CAUSE OF DEATH (A) DUE TO ASPIRATION PNEUMONITIS (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS	
19A. DATE OF OPERATION GASTROSTOMY 6/30/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FOR FEEDING		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-12 1965 to 7-4 1965, that (I) (we) last saw the deceased alive on 7-4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Quintin L. Uy		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-4-65	
23C. PHYSICIAN'S NAME (Type) QUINTIN L. UY		23D. ADDRESS FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 7, 1965		24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY	
24D. LOCATION (City, town, or county) (State) PARKVILLE, MARYLAND.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR John B. ...			



W-300

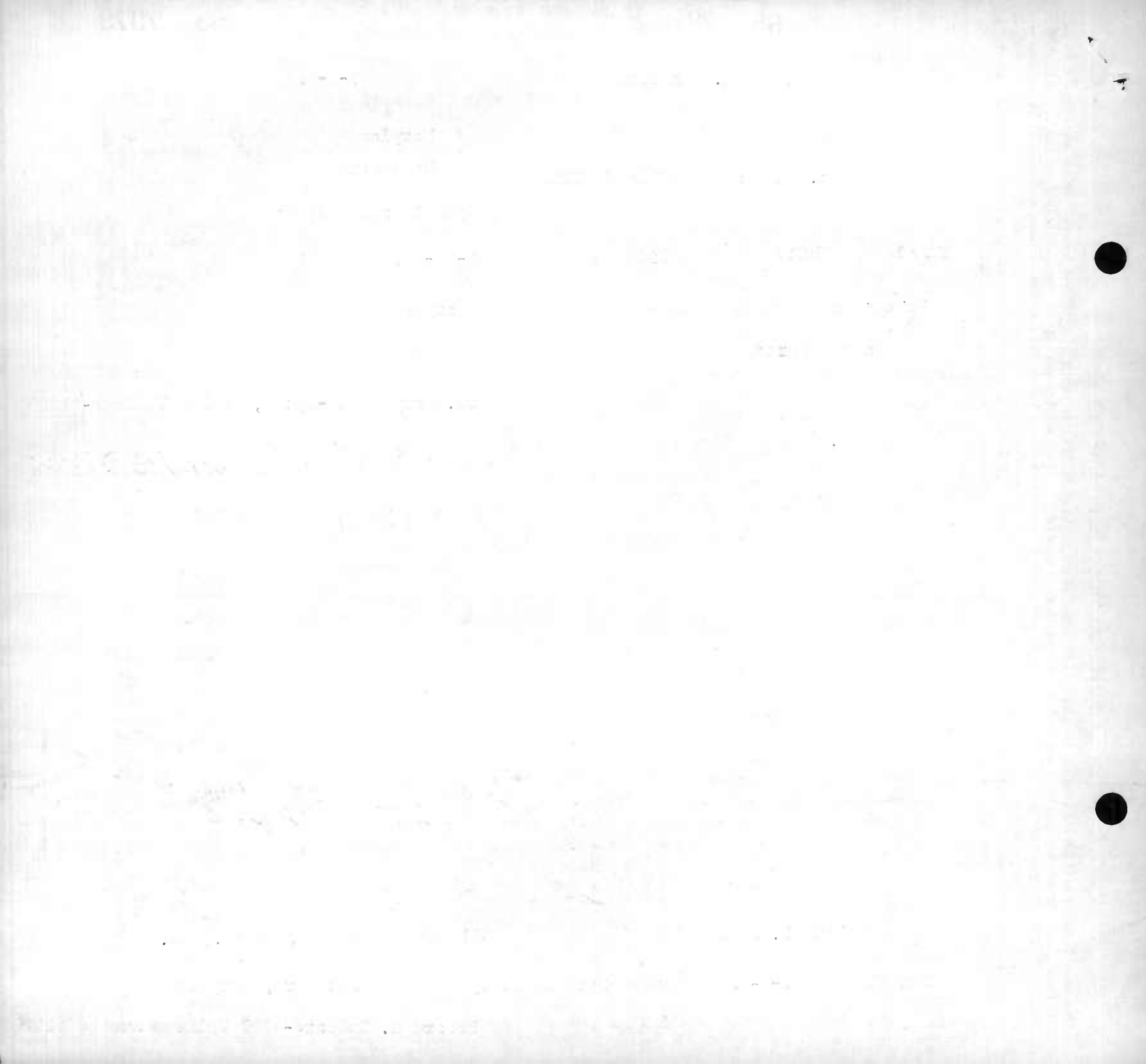
65 7078		BALTIMORE CITY HEALTH DEPARTMENT		65 7078	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		EDWARD WHITE		2. DATE AND HOUR PRONOUNCED DEAD July 5, 1965 9:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
2919 Huntingdon Avenue		D. STREET ADDRESS (If rural, give location)		2919 Huntingdon Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH April 28, 1933	9. AGE (In years last birthday) 32	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY American Can		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Vincent P. White.		14. MOTHER'S MAIDEN NAME Madeline Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 1952		16. SOCIAL SECURITY NO. 216 28 5581		17. INFORMANT Joseph White. 7802 Wynbrook Rd.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERSTITIAL MYOCARDITIS AND MEMBRANOUS GLOMERULONEPHRITIS.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/6/65	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 7/9/65		23C. NAME OF CEMETERY or CREMATORY Parkwood	
24A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		24B. NAME OF REGISTRAR Robert E. Faldut		24C. FUNERAL DIRECTOR Austin E. Donovan 3818 Roland Ave	

April 28, 1933
D. S.
Vincent J. White
SIC 75
SIC 75
SIC 75

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

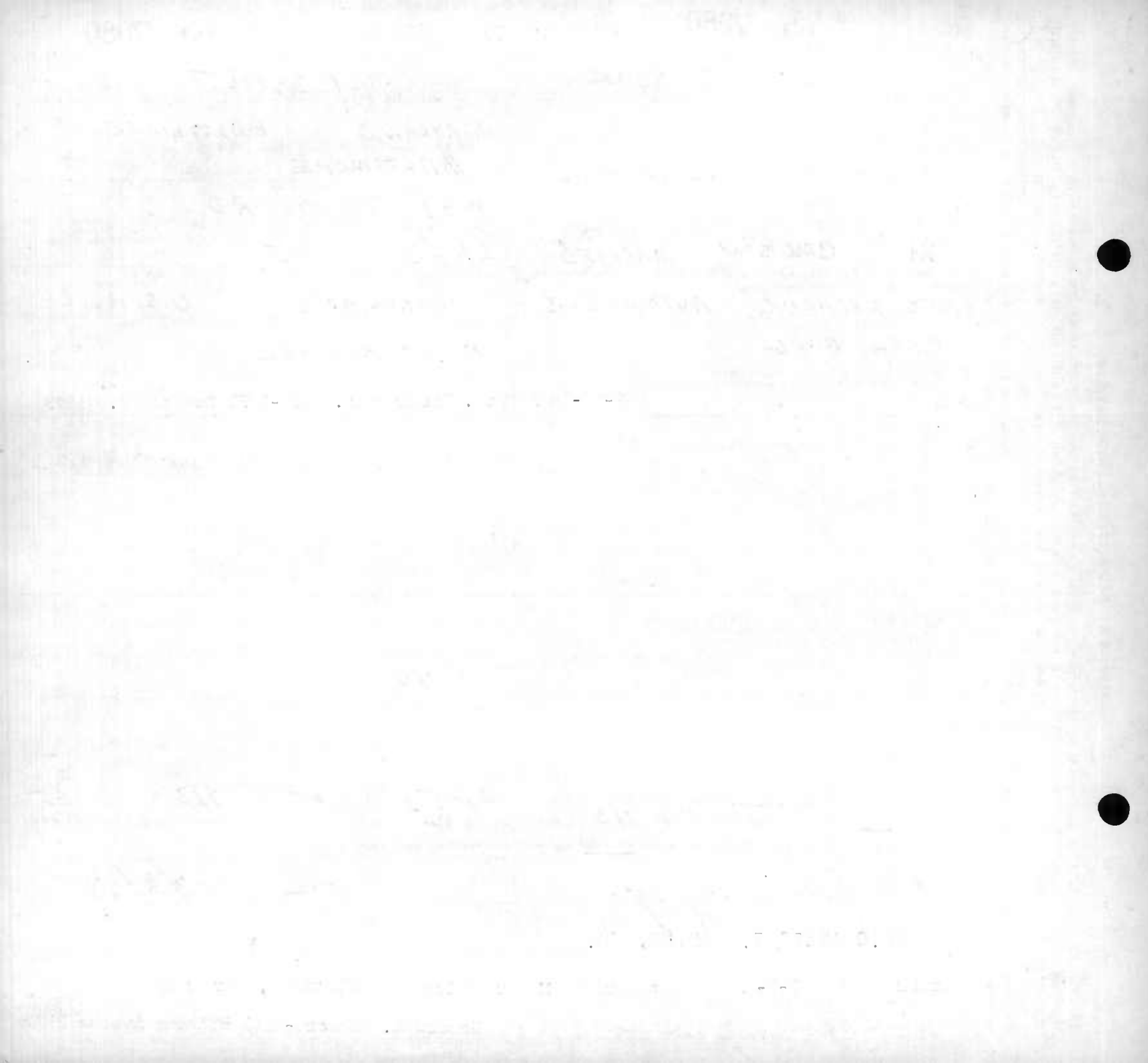
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7079	
BIRTH NO. 65 7079		CERTIFICATE OF DEATH		Registered No. 65 7079	
1. NAME OF DECEASED (Type or Print) Lillie K. Sanford			2. DATE AND HOUR OF DEATH 7-3-65		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Apt. #1 Oaklee Village 21229			A. STATE Maryland B. COUNTY Baltimore		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow			8. DATE OF BIRTH 12-26-1875		
9. AGE (In years last birthday) 89			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Samuel Bottom			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Mary Chelf-Apt 1, Oaklee Village-21229			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Arteriosclerotic C.V. dis (C) _____ INTERVAL BETWEEN ONSET AND DEATH 15 min.			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 1963 to July 3 1965, that (I) (we) last saw the deceased alive on July 3 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earl I. Pass			23B. DATE SIGNED 7-6-65		
23C. PHYSICIAN'S NAME (Type) Earl I. Pass			23D. ADDRESS M.D. 4001 Wilkens Avenue, Balto., Md. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Avenue 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

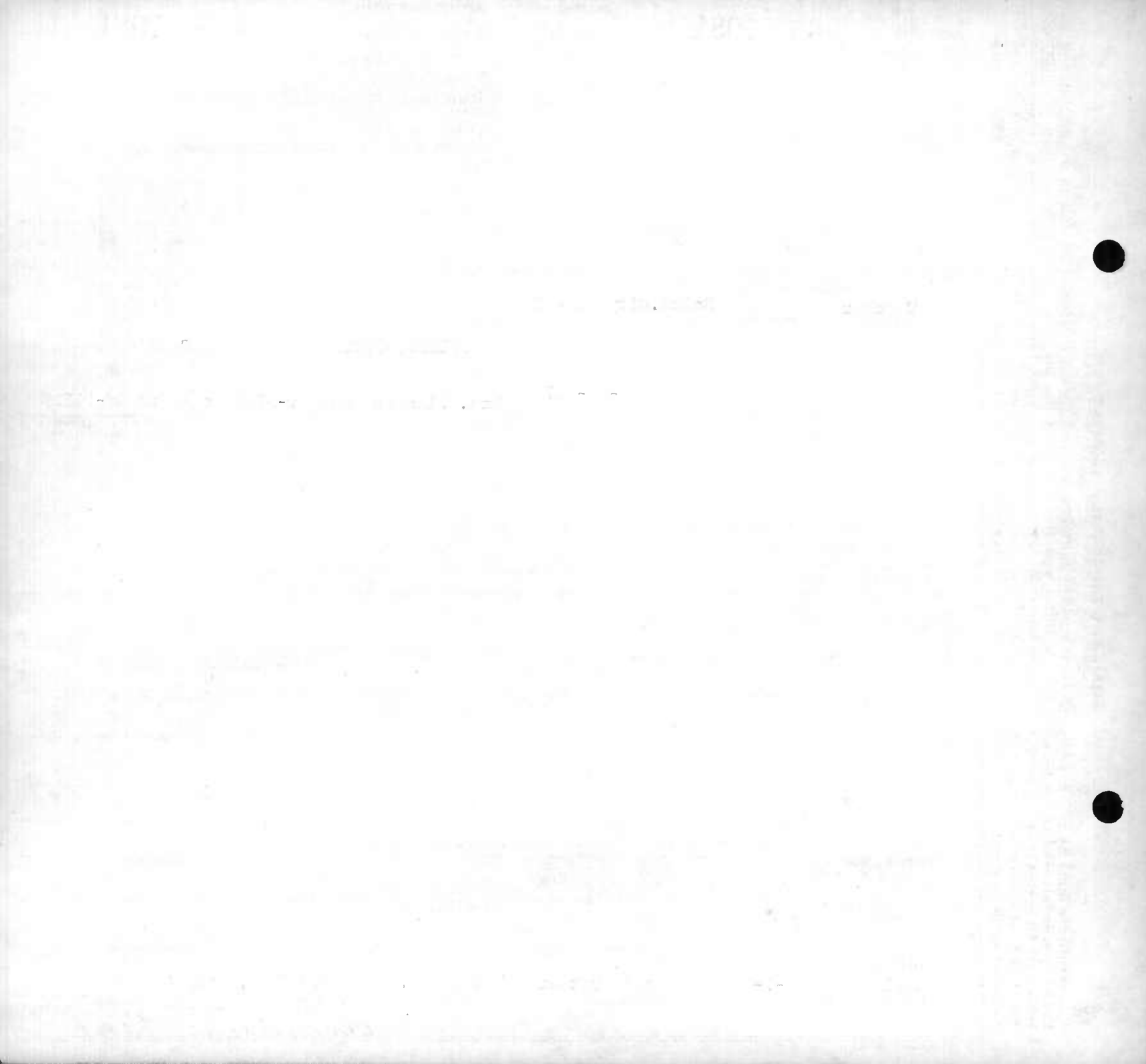
Baltimore City Health Department				Registered No. 65 7080	
BIRTH NO. 65 7080		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES J. BURG		2. DATE AND HOUR OF DEATH JULY 3, 1965 8:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44		A. STATE MARYLAND B. COUNTY BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-52			
		D. STREET ADDRESS (If rural, give location) 1051 DESOTO RD.			
5. SEX M	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/14/30	9. AGE (In years lost birthday) 35	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY AUTO MOBILE		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CARL BURG		14. MOTHER'S MAIDEN NAME ANNA KIMMEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-28-1885		17. INFORMANT ADDRESS Mrs. Virginia E. Burg-1051 DeSoto Rd. 21223	
18. 204.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) ACUTE MYELOGENOUS LEUKEMIA DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/25 19 65 to 7/3 19 65, that (I) (we) last saw the deceased alive on 7/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles E. Boring Jr.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/65	
23C. PHYSICIAN'S NAME (Type) DR. CHARLES E. BORING, JR.		23D. ADDRESS M.D. Howard H. Hubbard-4107 Wilkens Avenue 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-65		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park	
				24D. LOCATION (City, town, or county) (State) Elkridge, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Avenue 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

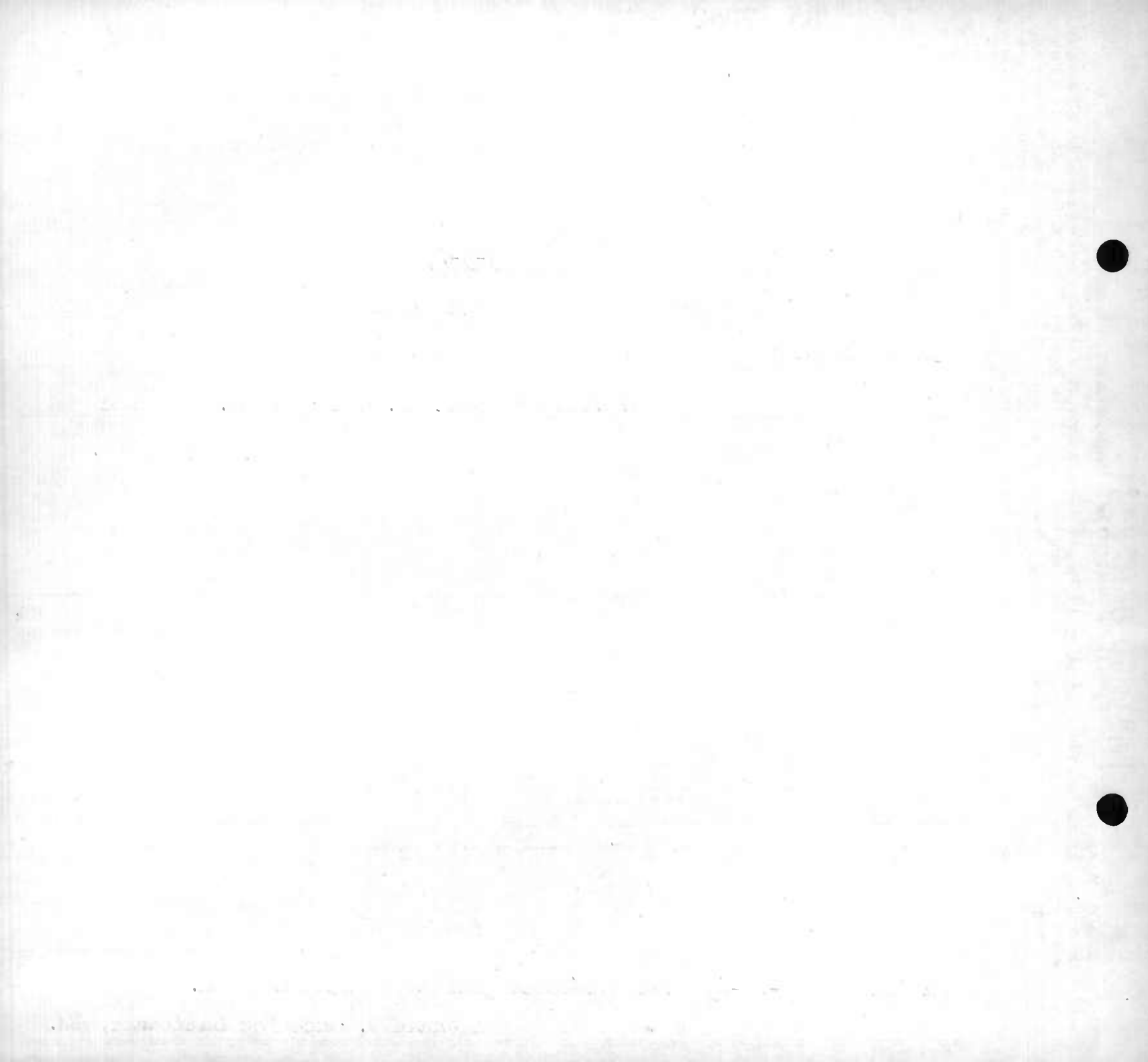
BIRTH NO. 65 7081		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7081	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Nelson, Mrs. Irene		
2. DATE AND HOUR OF DEATH 7/4/65 5:30 A.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		
A. STATE MARYLAND			B. COUNTY		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			4637 Manordene Road #29		
6. SEX F	7. RACE W	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) D	9. DATE OF BIRTH 8/6/1919	10. AGE (In years last birthday) 45	11. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10B. KIND OF BUSINESS OR INDUSTRY Balto. City School		
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Elmer Nels Sorenson		
14. MOTHER'S MAIDEN NAME XXXXXXXXXX Clara Helen Grulin			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 218-34-2179			17. INFORMANT ADDRESS Mrs. Eleanor Lindner-5717 Oakshire Rd-21229		
18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO Multiple Metastasis Cancer - brain		
(B) DUE TO			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/24 19 65 to 7/4 19 65, that (I) (we) last saw the deceased alive on 7/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Octavio A. Ruiz M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Octavio A. Ruiz M.D.				23D. ADDRESS Bon Secours Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-65		24C. NAME OF CEMETERY or CREMATORY United Brethren Church Cem.	
24D. LOCATION Myersville, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR 4107 Wilkens Ave ADDRESS 21229		24H. SIGNATURE Hubbard Funeral Home		24I. ADDRESS 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7082				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7082	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANGELINA S. HELLMAN				2. DATE AND HOUR OF DEATH JULY 6, 1965 6:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND.		B. COUNTY 27-01	
2911 LOUISE AVE. 21214				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2911 LOUISE AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-3-1922	9. AGE (In years lost birthday) 43	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Lazzaro				14. MOTHER'S MAIDEN NAME Rose Culotta			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214166630		17. INFORMANT James S. Hellman, Sr.		ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 170X I GENERALIZED MALIGNANT METASTASES ANTECEDENT CAUSES CARCINOMA RIGHT BREAST DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) GENERALIZED MALIGNANT METASTASES (B) CARCINOMA RIGHT BREAST (C)		INTERVAL BETWEEN ONSET AND DEATH Hyp 4 mo	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 04-6-61		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA BREAST		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/16 1965 to 7/6 1965, that (I) last saw the deceased alive on 7/6 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. ALESSI M.D.				23B. DATE SIGNED 7/7/65		23C. PHYSICIAN'S NAME (Type) S. A. ALESSI	
				23D. ADDRESS 6217 HARFORD RD.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7-10-65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

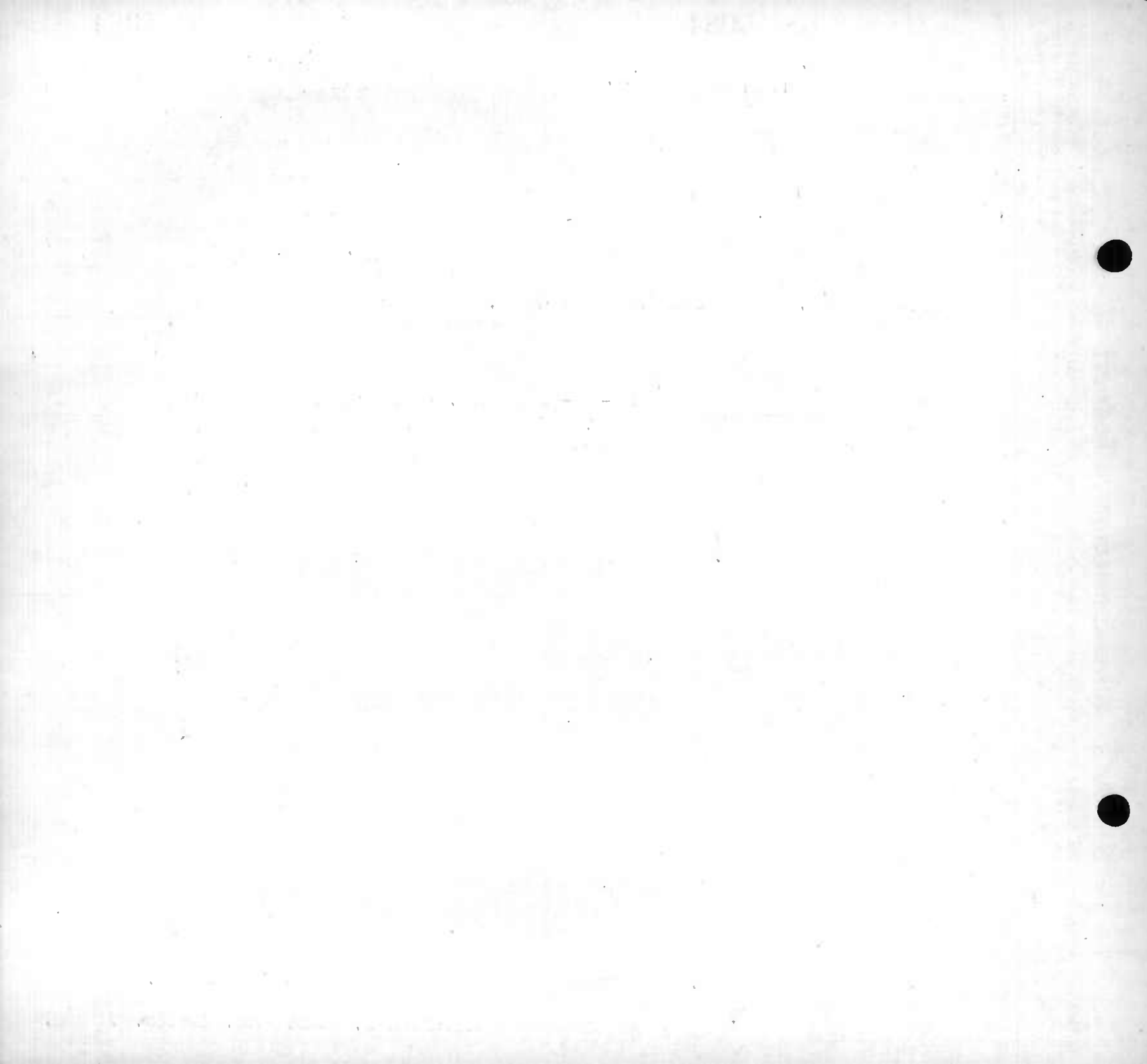
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 7083				
BIRTH NO. 65 7083					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) VICTOR SANDA					2. DATE AND HOUR OF DEATH 7-5-65 10. PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND B. COUNTY Wicomico C. CITY OR TOWN (If outside city limits, write RURAL and give township) SALISBURY D. STREET ADDRESS (If rural, give location) 72-12 SPRINGHILL Road				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9-2-00	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Male Nurse			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN PHILIP Sanda					14. MOTHER'S MAIDEN NAME ELIZABETH Hunslick				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 546382167		17. INFORMANT Mrs Catherine M. Wood		ADDRESS same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 199.2 I Abdominal Cancer, DUE TO etiology unknown					INTERVAL BETWEEN ONSET AND DEATH 1 year				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 5 1965 to July 6 1965, that (I) (we) last saw the deceased alive on July 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Guy R. Newell M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 6 '65		
23C. PHYSICIAN'S NAME (Type) DR. GUY NEWELL					23D. ADDRESS The Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7-8-65		24C. NAME of CEMETERY or CREMATORY Wicomico Mem. Park		24D. LOCATION (City, town, or county) (State) Wicomico County Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

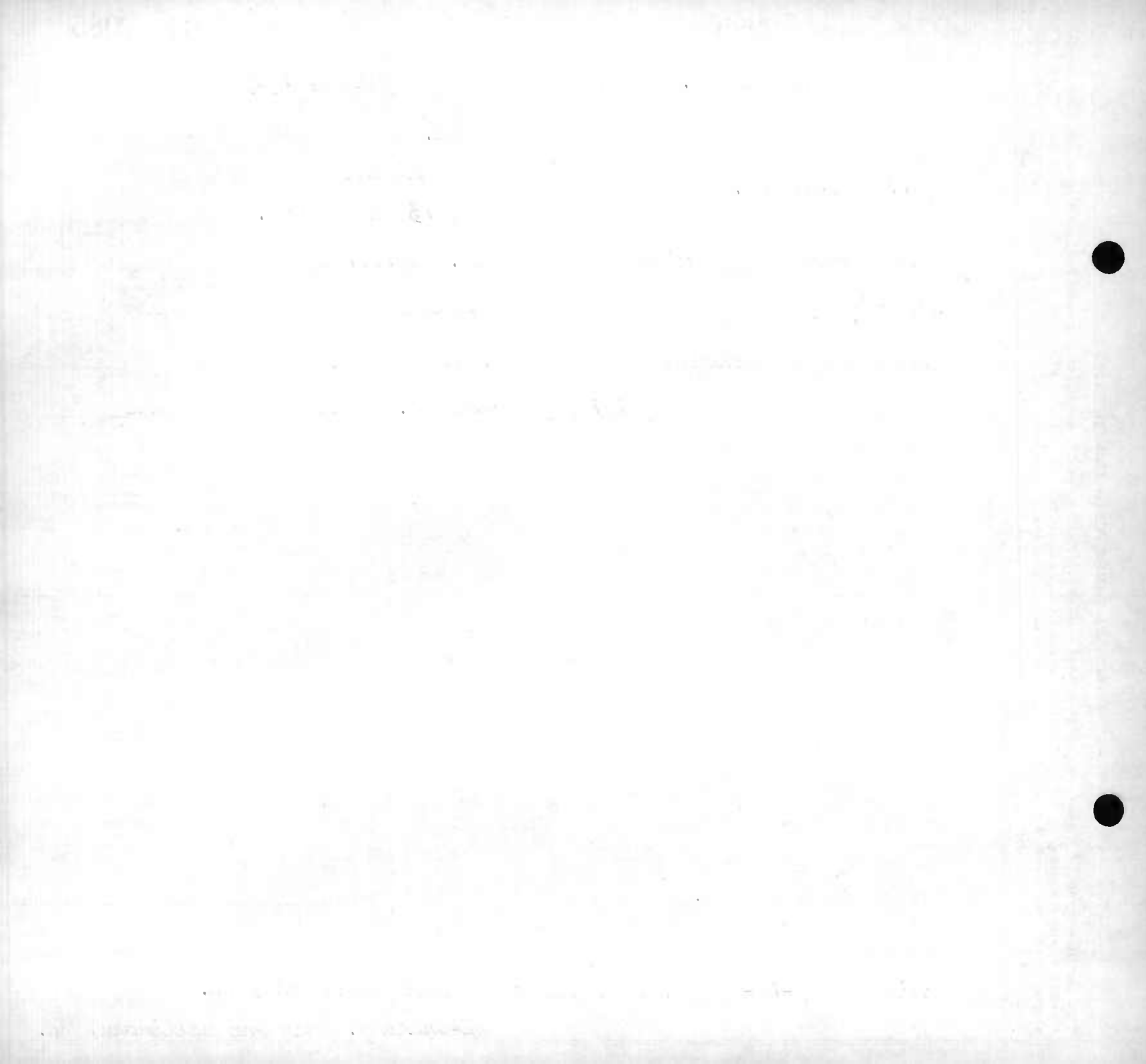
BIRTH NO. 65 7084				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7084	
1. NAME OF DECEASED HARRY WILLIAMSON Sr.				2. DATE AND HOUR OF DEATH 7-6-65 11:45 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #34 53-00 D. STREET ADDRESS (If rural, give location) 9824 MAGLEDT ROAD					
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10-7-98 95.	9. AGE (In years lost birthday) 68 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Supt.				10B. KIND OF BUSINESS OR INDUSTRY John Hopkins Hosp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE WILLIAMSON				14. MOTHER'S MAIDEN NAME MARY ANN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-03-9857		17. INFORMANT Mrs. Anna Williamson		ADDRESS (Same)	
18. 260X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Latent Diabetes mellitus				CAUSE OF DEATH (A) DUE TO Myocardial Infarction 3 days (B) DUE TO Arteriosclerotic Cardiovascular Disease (C) Latent Diabetes mellitus many years				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 7/3 1965 to 7/6 1965 , that (1) (we) last saw the deceased alive on 7/6/65 19 65 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Barry J. Zacherle						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Typed) Barry J. Zacherle						23D. ADDRESS 550 N. Broadway, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965				25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7085	
BIRTH NO. 65 7085		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Bridget A. Reilly</i>		2. DATE AND HOUR OF DEATH <i>July 6, 1965 10 P. M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4211 Sanner Ave.</i>		A. STATE <i>Md.</i> B. COUNTY <i>26-02</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>4213 Sanner Ave.</i>			
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>Jan. 22, 1881</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Bartholomew McDonough</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Berry</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2151036530</i>		17. INFORMANT <i>James M. Reilly</i> ADDRESS <i>same</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO <i>Coronary occlusion</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>Arteriosclerosis</i>			
		(C) <i>Hypertension</i>			
		<i>Arterio-sclerosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Senility</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 21, 1965</i> to <i>July 6, 1965</i> , that (I) (we) last saw the deceased alive on <i>July 6, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter A. Anderson</i> M.D.				23B. DATE SIGNED <i>7/7/65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>7-10-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery Baltimore, Md.</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkley</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>		25D. ADDRESS			



65 7086

BALTIMORE CITY HEALTH DEPARTMENT

65 7086

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANNETTE GAIL TRACY

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1965 4:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Towson

D. STREET ADDRESS (If rural, give location)

301 Washington Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

March 16, 1964

9. AGE (In years
last birthday)

1

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Bryon

14. MOTHER'S MAIDEN NAME

Edith Tracy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Balto. Co. Welfare Dept., Towson, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Aspiration of Vomitus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Activation of Vomiting Reflex
DUE TO

(C) Insertion of Baby Rattle in Mouth.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

House

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Redline Road, White Marsh, Md.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 5 '65 P

21E. INJURY OCCURRED

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

Vomiting induced by foreign body in/

mouth.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-9-65

23C. NAME of CEMETERY or CREMATORY

GLEN HAVEN

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Francis H. Miller 214 Linden Ave

1000

1000

1000

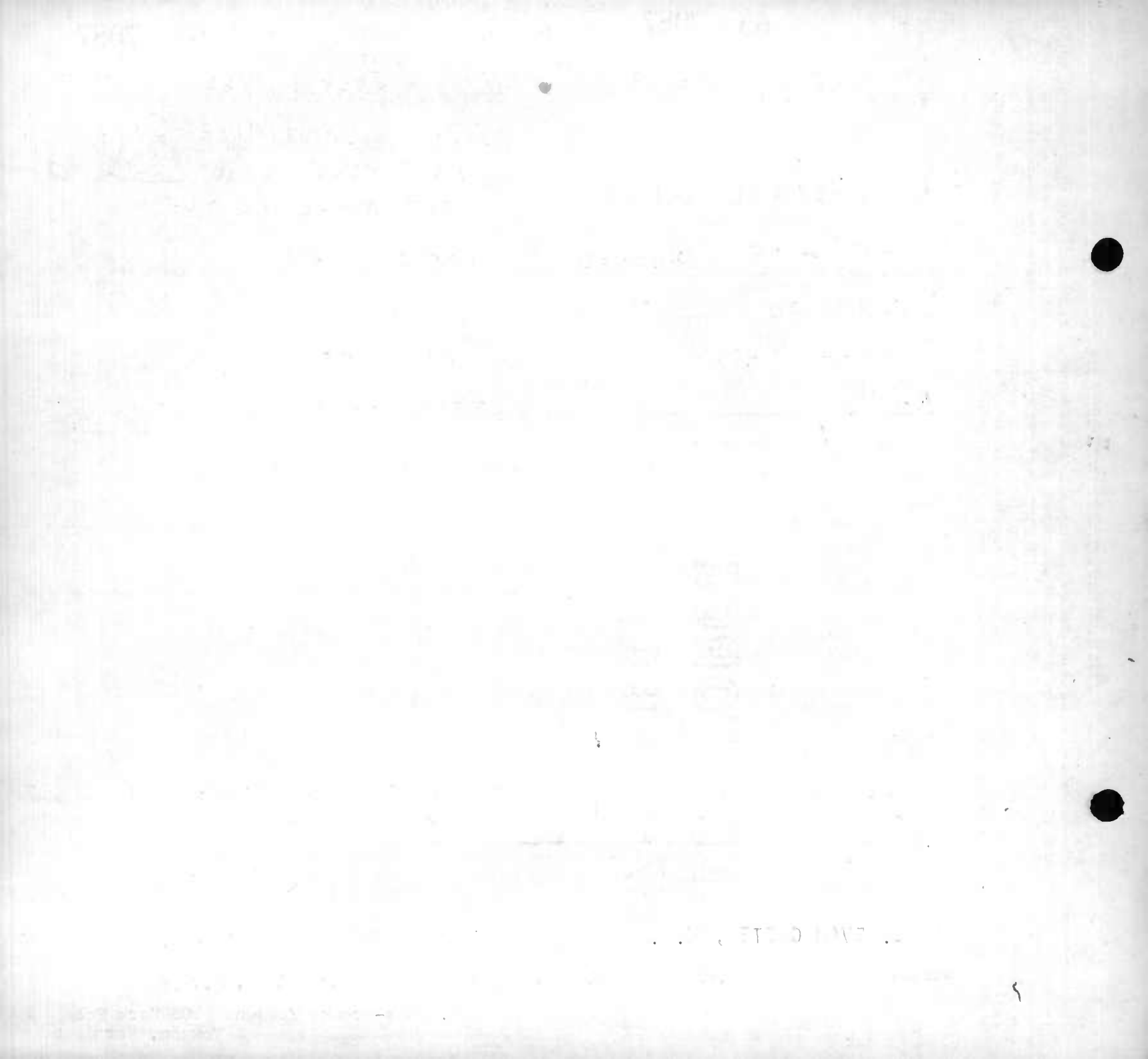
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FUNERAL DIRECTOR: IMPORTANT

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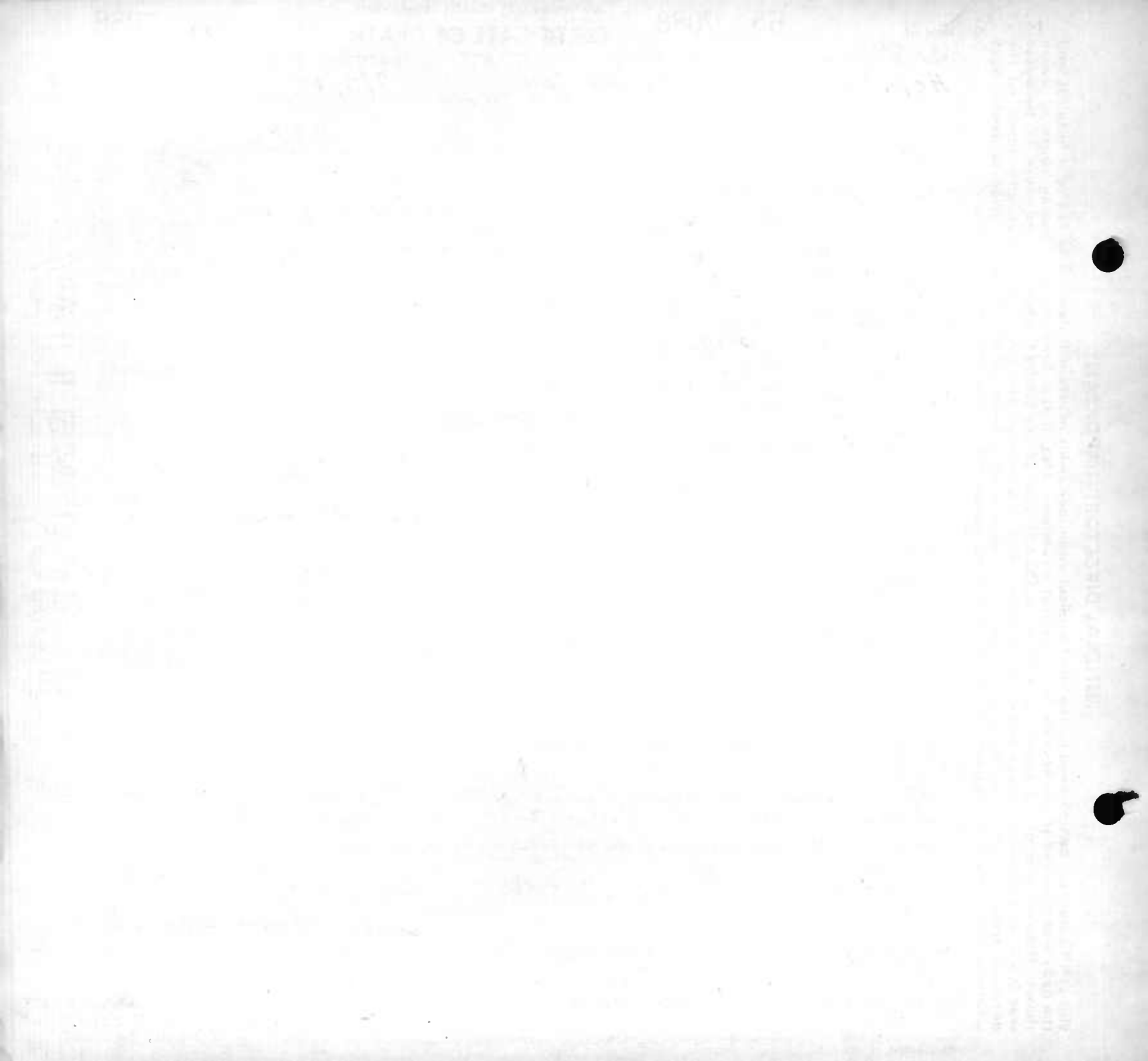
BALTIMORE CITY HEALTH DEPARTMENT											
65 7087											
BIRTH NO. 65 7087											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) FOREMAN, ESTELLE MASON											
2. DATE AND HOUR OF DEATH JULY 1, 1965 15:55 P.M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
44 UNION MEMORIAL HOSPITAL						A. STATE MD. B. COUNTY BALTIMORE CITY					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)						D. STREET ADDRESS (If rural, give location)					
BALTIMORE						53-00 517 REGESTER AVE.					
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 1/26/83		9. AGE (in years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOSEPH MASON		14. MOTHER'S MAIDEN NAME SARA MARTIN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT HELEN BLATTEAU		18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION		20. ADDRESS 517 REGESTER AVE. BALTIMORE, MD.		21. INTERVAL BETWEEN ONSET AND DEATH		22. I certify that the (this hospital) attended the deceased from JUNE 27 1965 to JULY 1 1965, that the (we) last saw the deceased alive on JULY 1 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) not view the body after death.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. ANTECEDENT CAUSES		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL CERTIFICATION		22. MEDICAL CERTIFICATION		23. MEDICAL CERTIFICATION	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(Coronary heart disease / Dill)		(Massive aspiration)		(Interval between onset and death)		(Other significant conditions contributing to the death but not related to the disease or condition causing it.)	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOBIOGRAPHY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22A. SIGNATURE L. Evan Custer, M.D.		22B. DATE SIGNED JULY 1, 1965	
22C. PHYSICIAN'S NAME (Type) L. EVAN CUSTER, M.D.		22D. ADDRESS UNION MEMORIAL HOSPITAL		23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE July 5, 65		23C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23D. LOCATION Pikesville, Maryland	
24A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		24B. NAME OF REGISTRAR Robert E. Jackson		24C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		24D. ADDRESS 1050 York Road Towson, Maryland		25A. VS 150-REV. 1/1/65		25B. 19650006595	



FUNERAL DIRECTOR: IMPORTANT

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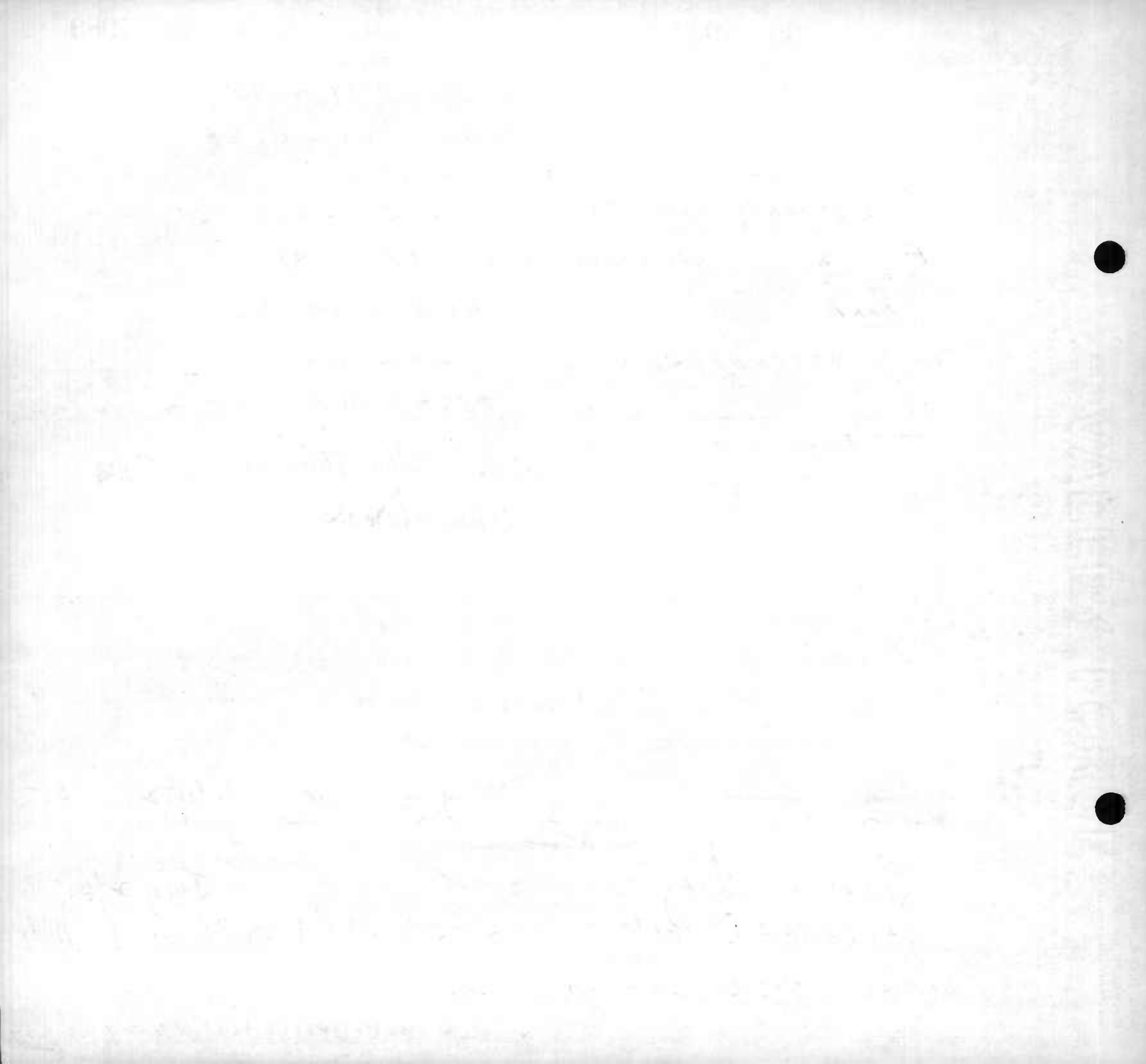
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7088	
BIRTH NO. 65 7088		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) HELEN MARQUERITE McKINSTRY		7/2/65 4:10 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION St. Church Home & Hospital		A. STATE Md. B. COUNTY U.S.A.	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
		D. STREET ADDRESS (If rural, give location) 214 CHARTREY Rd.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 1-5-1914
		9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10B. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK McKINSTRY		14. MOTHER'S MAIDEN NAME RUTH TRUE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NOT KNOWN		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS	
18. 43441		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Acute Coronary Inf. DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) COP PULMONALE DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 24 1965 to July 2 1965 , that (I) (we) last saw the deceased alive on July 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert E. Fairbank M.D.		23B. DATE SIGNED 7/2/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Church Home Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1965	
24C. NAME of CEMETERY or CREMATORY Dulany Valley Cemetery		24D. LOCATION (City, town, or county) (State) Timonium, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Rd. Towson, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7089		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7089	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>ROTH McDONNELL</u>			JULY 2, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 HILL CREST NURSING HOME</u> <u>212 STONEY RUN LANE</u>			A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>TOWSON</u> <u>53-00</u>		
			D. STREET ADDRESS (If rural, give location) <u>625 HASTINGS RD #4</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>3-19-1878</u>	9. AGE (In years lost birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>HARRISBURG PA.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>WM. K. McDONNELL, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>BARBARA RUOSILA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT <u>BERT C. McDONNELL</u>		
			ADDRESS <u>625 HASTINGS RD TOWSON #4</u>		
18. <u>450.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Cardiac Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		
			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 6, 1960</u> to <u>July 2, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 2, 1965</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <u>Laurence C. Post</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 2/65</u>
23C. PHYSICIAN'S NAME (Type) <u>LAURENCE C. Post</u>			23D. ADDRESS <u>6505 YORK RD Baltimore 12 Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-3-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>EAST HARRISBURG</u>	
				24D. LOCATION (City, town, or county) (State) <u>HARRISBURG PA.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>WM. COOK-BROOKS TOWSON 1050 YORK RD 4</u>	



BIRTH NO.

65 7090

65 7090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET C. DOLAN

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1965 2:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

800 McAleer Court

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

May 20, 1887 78

9. AGE (in years
last birthday)II Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk - Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

(Unknown) Schmitt

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-14-9913

17. INFORMANT

ADDRESS

James J. Hackmann 449 S. Augusta Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary Embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Thrombophlebitis, right popliteal vein.
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 8, 65

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

WALLIE Y. TORGE

5450 11164

Charles J. Torge

BIRTH NO.

65 7091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 7091

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES CARTER

2. DATE AND HOUR PRONOUNCED DEAD

7/7/65 1:05 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY St. Mary's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Mechanicsville Box #20

D. STREET ADDRESS (If rural, give location)

RURAL

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

12-28-1956

9. AGE (In years
last birthday)

9

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STUDENT

10B. KIND OF BUSINESS OR INDUSTRY

SCHOOL

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANCIS JOSEPH CARTER

14. MOTHER'S MAIDEN NAME

MARY MARTHA SCRIBER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

N/A

17. INFORMANT

MRS MARTHA CARTER

ADDRESS

MECHANICSVILLE,
MARYLAND

18.

E81241

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Multiple traumatic injuries

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

St. Joseph's Project Road

68-00

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 6 65 8:45 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian

struck by automobile

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-10-65

23C. NAME OF CEMETERY or CREMATORY

ST. JOSEPH'S CEM.

23D. LOCATION

(City, town, or county)

(State)

MORGANZA, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JUL 7 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ROBINSON FUNERAL HOME

ADDRESS

LEONARDTOWN, MD

RORAL

12-22-1912

MARYLAND

SCHOOL

STUDENT

Francis Joseph CARTER

Mrs MARTHA CARTER


M/A

NO

Prune No-62 St Joseph's Maryknoll
St Joseph's Maryknoll
St Joseph's Maryknoll

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7092				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7092	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ellis Victor Wright				2. DATE AND HOUR OF DEATH July 2, 1965 3:00 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1629 Druid Hill Ave.			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-17-1888	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Photographer		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Esaw Wright				14. MOTHER'S MAIDEN NAME Lucy Carter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-34-7779		17. INFORMANT ADDRESS Lydia Wright-1629 Druid Hill Ave			
18. 465X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Probable Pulmonary Embolism (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-18-65 19 to 7-2-65 19, that (I) (we) last saw the deceased alive on 7-2-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-2-65	
23C. PHYSICIAN'S NAME (Type) Marie Rigaud		23D. ADDRESS M.D. 1514 Division St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/65		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Pk.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1965		25B. NAME OF REGISTRAR Robert E. Falker, M.D.		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7093				BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				Registered No. 65 7093			
1. NAME OF DECEASED (Type or Print) TERRY G. RUSSELL								2. DATE AND HOUR OF DEATH JULY 3, 1965 3:55 P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3011 W. NORTH AVE							
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH MARCH 10, 1894		9. AGE (In years last birthday) 71		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10B. KIND OF BUSINESS OR INDUSTRY SELF-Employed				11. BIRTHPLACE (State or foreign country) MACK LAMBURG CO, VA				12. CITIZEN OF WHAT COUNTRY? U. S. A			
13. FATHER'S NAME SANDY RUSSELL								14. MOTHER'S MAIDEN NAME ALICE WHITTLE							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 227-22-6260				17. INFORMANT MRS. AVERKINA RUSSELL				ADDRESS 3011 W. NORTH AVE			
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								CAUSE OF DEATH (A) CEREBROVASCULAR THROMBOSIS DUE TO WITH ENCEPHALOMELACIA				INTERVAL BETWEEN ONSET AND DEATH 7 DAYS			
								(B) ARTERIOSCLEROSIS DUE TO				10 YRS.			
								(C)							
								II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				ESSENTIAL HYPERTENSION			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from JUNE 26, 1965 to JULY 3, 1965 , that (I) (we) last saw the deceased alive on JULY 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE Marvin Goldstein M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED JULY 3, 1965							
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN M.D.								23D. ADDRESS 5334 LIBERTY HEIGHTS AVE.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE JULY 7, 1965		24C. NAME OF CEMETERY or CREMATORY DIAMOND GROVE CEMETERY				24D. LOCATION (City, town, or county) (State) UNION LEVEL, VIRGINIA					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR Robert E. Jackson				25C. FUNERAL DIRECTOR HERBERT E. NOTTER				ADDRESS 3035 W. NORTH AVE			

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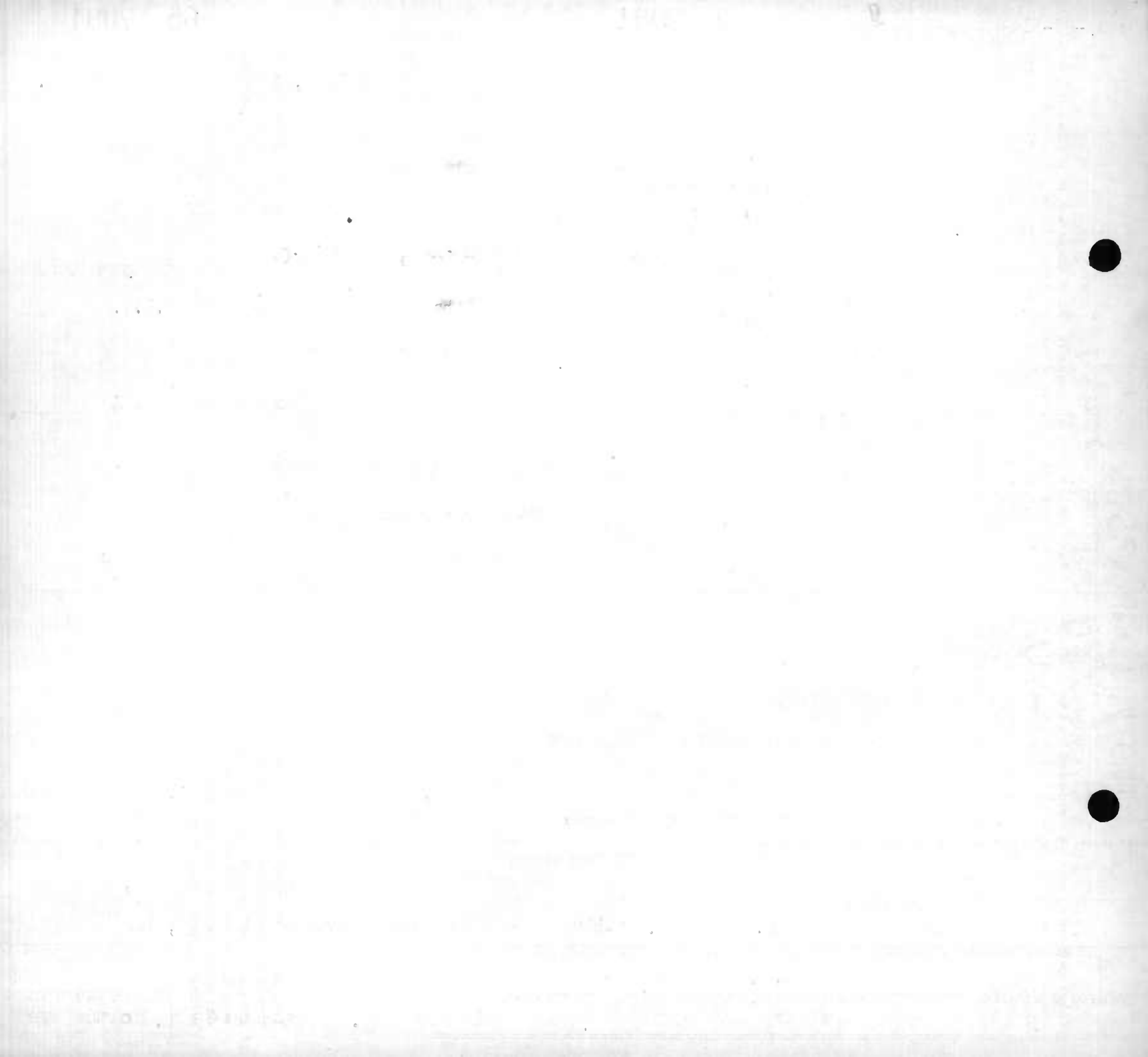
1956

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

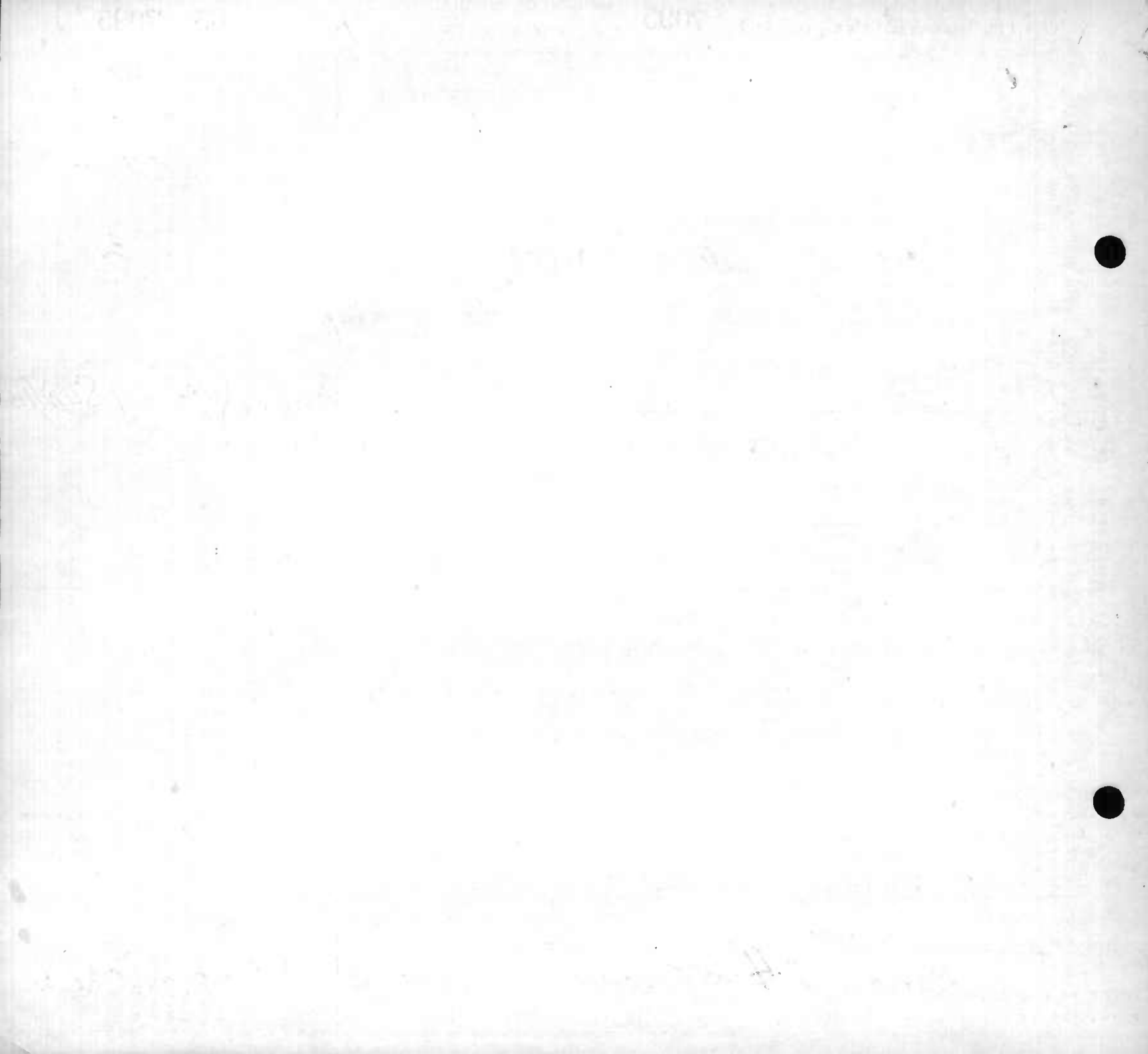
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
4-654		65 7094		65 7094	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Earline Arnold			July 3, 1965 7:10 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			Maryland Baltimore		
5. SEX			6. DATE OF BIRTH		
Female			Aug-23, 1904		
7. RACE			9. AGE (In years last birthday)		
Negro			60		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Housewife			Alabama (Tuscalusa)		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Home			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lewis Arnold			Jessie McClister		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			RECORDS BCH 4940 Eastern Avenue #24		
17. INFORMANT			ADDRESS		
18. 331X I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Cerebral Vascular Accident		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			DUE TO		
ANTECEDENT CAUSES			(B) Arteriosclerosis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO		
II			(C) Hypernatremia		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			6 Weeks		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			Many Years		
20A. AUTOPSY? (Yes or No)			2 Days		
No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 10, 1965 to July 3, 1965, that (I) (we) last saw the deceased alive on July 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Dr. Howard K. Rathbun			July 3, 1965		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Dr. Howard K. Rathbun			4940 Eastern Avenue Baltimore, Maryland #24		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/7/65		Arbutus Memorial Park	
24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
(City, town, or county) (State)		JUL 7 1965		Herbert E. Nutter 3035 W. North Ave	
Baltimore County Maryland		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		Robert E. Nutter		Herbert E. Nutter 3035 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Elton, Md. 65</i> 7095				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>651-70987</i>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Baby Boy KYLE</i>		2. DATE AND HOUR OF DEATH <i>7/1/65</i> <i>9:55</i> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Belt</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>				D. STREET ADDRESS (If rural, give location) <i>Conowingo and Conowingo, Md.</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>6-30-65</i>	9. AGE (In years lost birthday) <i>24 yrs. old</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Kyle</i>				14. MOTHER'S MAIDEN NAME <i>Jane Harvey</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>William Kyle Rising Sun, Md.</i>		ADDRESS
18. <i>7625 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Prematurity</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hyaline Mem. Disease + /or Atelectasis</i>				(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>65</i> to <i>July 1</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 1</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Grace Aruyao</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7-1-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Grace Aruyao</i>				23D. ADDRESS M.D. <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-4-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Freemount Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Near Nottingham, Pa.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Richard L. Goodie, Rising Sun, Md.</i>		ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 7096 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7096

M-200

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
CARROLL W. McGAHA		July 5, 1965 3:37 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		A. STATE Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 2606 Lauretta Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.	8. DATE OF BIRTH Nov. 7, 1901
9. AGE (In years last birthday) 63		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John S. McGaha		14. MOTHER'S MAIDEN NAME Ella G. Burton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Sarah R. McGaha		ADDRESS 1177 Granville Rd. (7)	

MEDICAL CERTIFICATION	18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease.		
	(A) DUE TO		
	(B) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/6/65	
Charles S. Petty, M.D.			
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	7-8-1965	Mt. Olivet	Lovettsville, Va.
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JUL 8 1965	Robert E. Farley, M.D.	G. Howard Strong	3207 W. North Ave.,

WALLEY & SONS

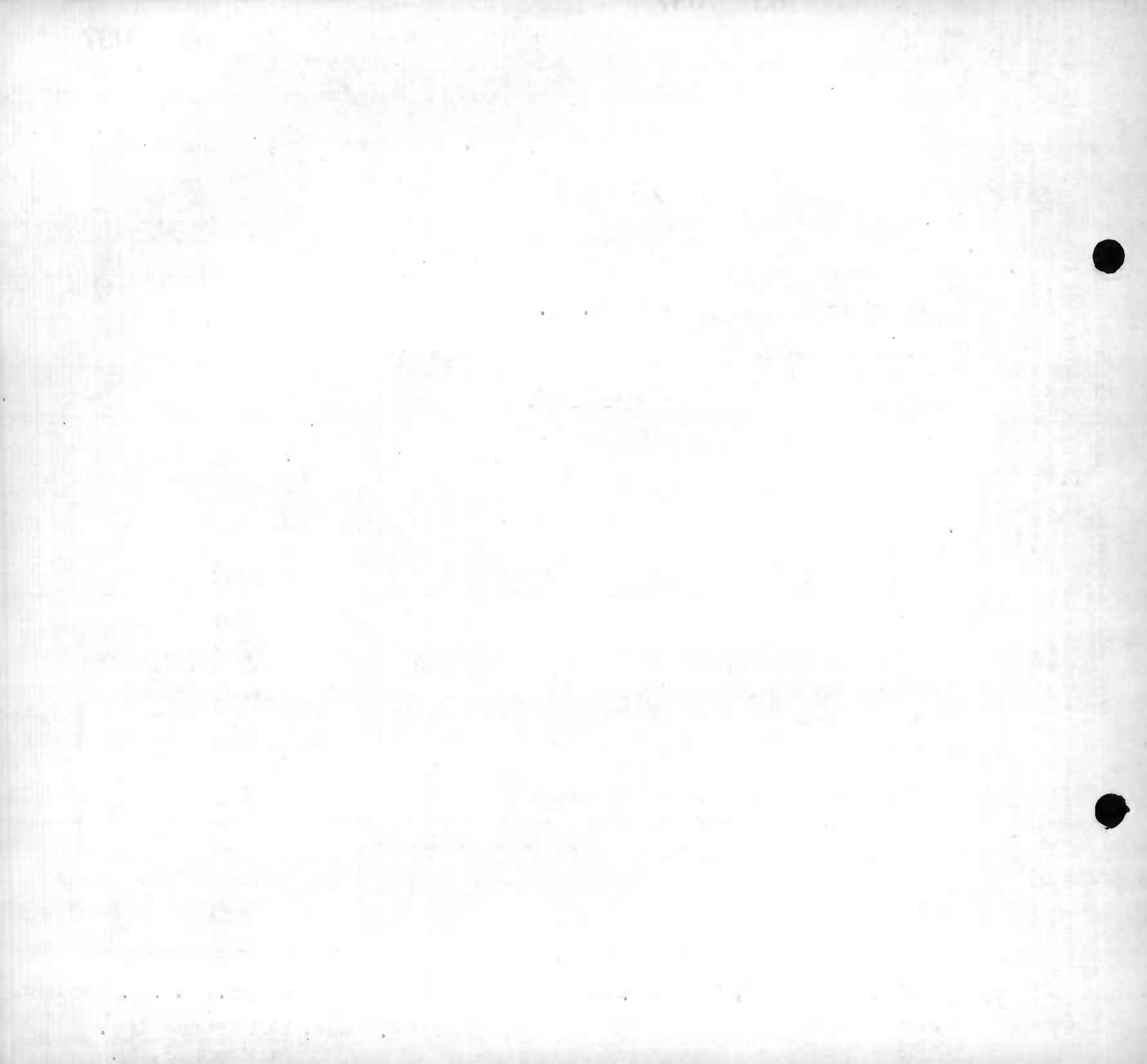
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

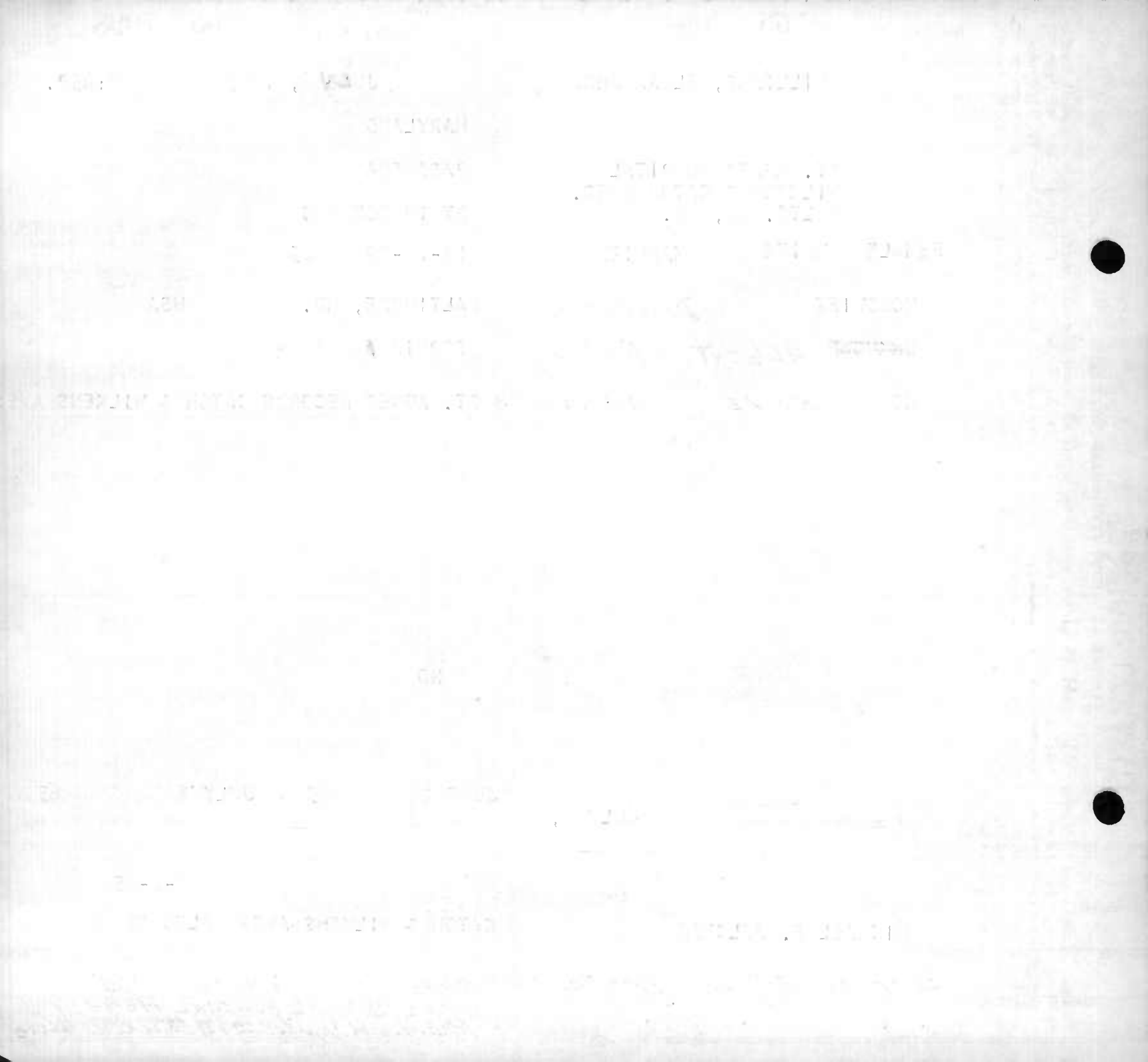
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				CERTIFICATE OF DEATH		65 7097	
1. NAME OF DECEASED (Type or Print) Frederick George Shettle				2. DATE AND HOUR OF DEATH 7/4/65 1 54 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 58 University Hospital BALTIMORE 1, Md.				A. STATE Md. B. COUNTY AA			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Severn Md. 5200				D. STREET ADDRESS (If rural, give location) Donaldson Ave			
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH May 10, 1890	9. AGE (in years last birthday) 75	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10B. KIND OF BUSINESS OR INDUSTRY Diamond Cab. Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frederick Shettle				14. MOTHER'S MAIDEN NAME Anna Rost			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 217-03-8504		17. INFORMANT Dorothy Widmyer Niece 1105 Bayard St			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Spurred mesenteric thrombosis artery c gangrene of entire small & part of large bowel.				INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 7/3		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED mesenteric thrombosis		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/3 1965 to 7/4 1965, that (I) (we) last saw the deceased alive on 7/3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> George J. Gonce				23B. DATE SIGNED 7/4/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 7, 1965	24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A.A.Co. Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7098				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7098	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAMS, FLORA ANNA				2. DATE AND HOUR OF DEATH JULY 6, 1965		7:45P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY AA			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA		52-00	
				D. STREET ADDRESS (If rural, give location) RT 10 BOX 98C			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 12-16-99	9. AGE (In years lost birthday) 65	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN ALBERT MILLER				14. MOTHER'S MAIDEN NAME SOPHIA KAISER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-03283		17. INFORMANT ADDRESS ST. AGNES RECORDS CATON & WILKENS AVES			
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GENERALIZED CARCINOMATOSIS DUE TO CARCINOMA OF THE BREAST DUE TO INTERVAL BETWEEN ONSET AND DEATH MONTHS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from JUNE 24 19 65 to JULY 6 19 65 , that (I) (<u>we</u>) last saw the deceased alive on JULY 6 , 19 65 and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.							
23A. SIGNATURE Michael E. Pelczar				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-6-65	
23C. PHYSICIAN'S NAME (Type) MICHAEL E. PELCZAR				23D. ADDRESS M.D. CATON & WILKENS AVES BALTO 29 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-9-65		24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Geo. L. Schwab FUNERAL HOME Francis H. Miller 2101 Franklin Ave			



BIRTH NO.

65 7099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 7099

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES J. BAUMANN

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1965

6:10 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

806 W. Pratt St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 20, 1912

9. AGE (In years
last birthday)

52

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chaneffeur

10B. KIND OF BUSINESS OR INDUSTRY

Cement

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Joseph Baumann

14. MOTHER'S MAIDEN NAME

Miranda Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

2

16. SOCIAL
SECURITY NO.

215 05 8468

17. INFORMANT

Joseph Baumann

ADDRESS

1537 Covington St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7 8 1965

23C. NAME of CEMETERY or CREMATORY

Balto. U. S. National

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 8

1965

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave.

UNITED STATES
DEPARTMENT OF AGRICULTURE

WATER RESOURCES

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7100				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7100	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Charles Arvey Denford				2. DATE AND HOUR OF DEATH July 6, 1965 1:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 303 Fonthill Ave.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/20/96	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter		10B. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustine Denford				14. MOTHER'S MAIDEN NAME Emily Wartz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/17/17 to 1/27/19		16. SOCIAL SECURITY NO. 215 18 7451		17. INFORMANT Records		ADDRESS V.A. Hospital, Baltimore, Md. 21218	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of right lung with wide- spread metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Carcinoma of right lung with wide- spread metastasis DUE TO (B) spread metastasis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
19A. DATE OF OPERATION 6/30/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of right lung		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from June 21 1965 to July 6 1965 , that (1) (we) last saw the deceased alive on July 6 1965 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) view the body after death.							
23A. SIGNATURE Donald H. Hooker				M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff <input checked="" type="checkbox"/> Phys.		23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) Donald H. Hooker, M.D.		23D. ADDRESS V.A. Hospital, 3900 Loch Raven Blvd. Baltimore, Maryland 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/65		24C. NAME OF CEMETERY or CREMATORY BALTO. NAT. CEM.		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR G. TRUMAN SCHWAB		ADDRESS 3512 Frederick Ave. (29)	

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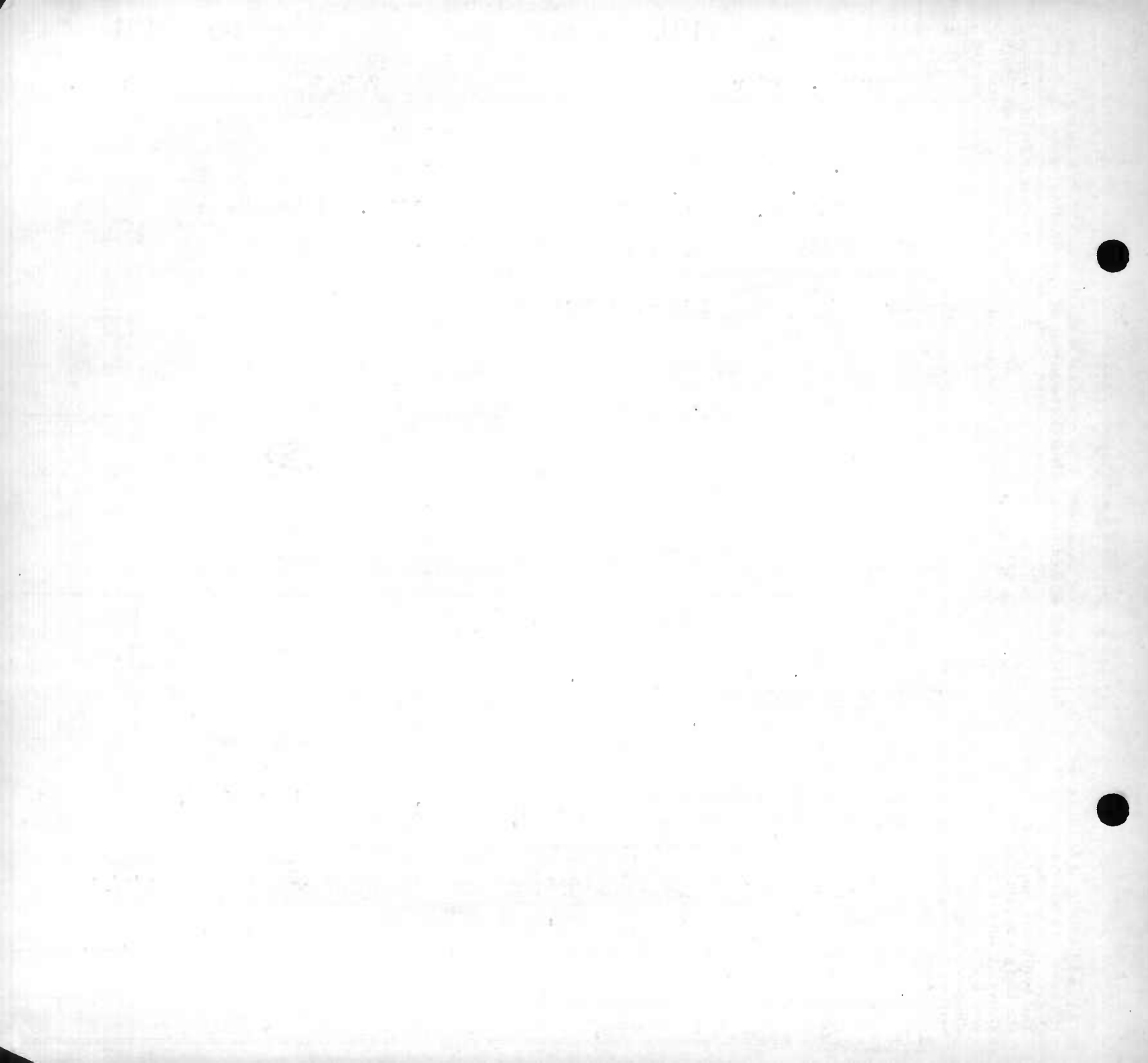
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7101				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7101	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) George A. Kerler			
2. DATE AND HOUR OF DEATH 7/5/65 7:52 P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital 1000 S. Caton Ave. Baltimore, Maryland 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) o 155 S. Collins Avenue							
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/9/16	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10B. KIND OF BUSINESS OR INDUSTRY Calvert Distillery		11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William F. Keeler				14. MOTHER'S MAIDEN NAME Bessie Hageman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1938 - 1945		16. SOCIAL SECURITY NO. 212-05-9452		17. INFORMANT Mrs. Mary C. Kerler		ADDRESS BALTO. MD.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Ventricular Fibrillation DUE TO (B) Acute Myocardial Infarction DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 24 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				None			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 5, 19 65 to July 5, 19 65, that (I) (we) last saw the deceased alive on July 5, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did not) view the body after death.							
23A. SIGNATURE Raphael Updike M.D.				23B. DATE SIGNED 7/5/65		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME of CEMETERY or CREMATORY Lakeview Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR G. TRUMAN Schnab		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7102	
BIRTH NO. 65 7102		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John (NMI) Ruberry		2. DATE AND HOUR OF DEATH 7/6/65 6:55 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Md. 21218		A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male		6. RACE Caucasian		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 10/29/89		9. AGE (In years last birthday) 75		10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworker		10B. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Pat Ruberry		14. MOTHER'S MAIDEN NAME Sophia Meyers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 218 09 8484		17. INFORMANT Records	
18. 527.1 + 260 X		CAUSE OF DEATH		ADDRESS V.A. Hospital, Baltimore, Md. 21218	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Chronic pulmonary emphysema		Years	
		(C) Cor Pulmonale		Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from June 13 19 65 to July 6 19 65 , that (1) (we) lost saw the deceased alive on July 6 19 65 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (1) view the body after death.					
23A. SIGNATURE R. W. Hamilton				23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) R. W. Hamilton				23D. ADDRESS V.A. Hospital, 3900 Loch Raven Blvd. Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 9 1965		24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) Frederick Road		24E. (State) Md		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965	
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR The Dippel Brothers Inc 1800 E Lombard St			

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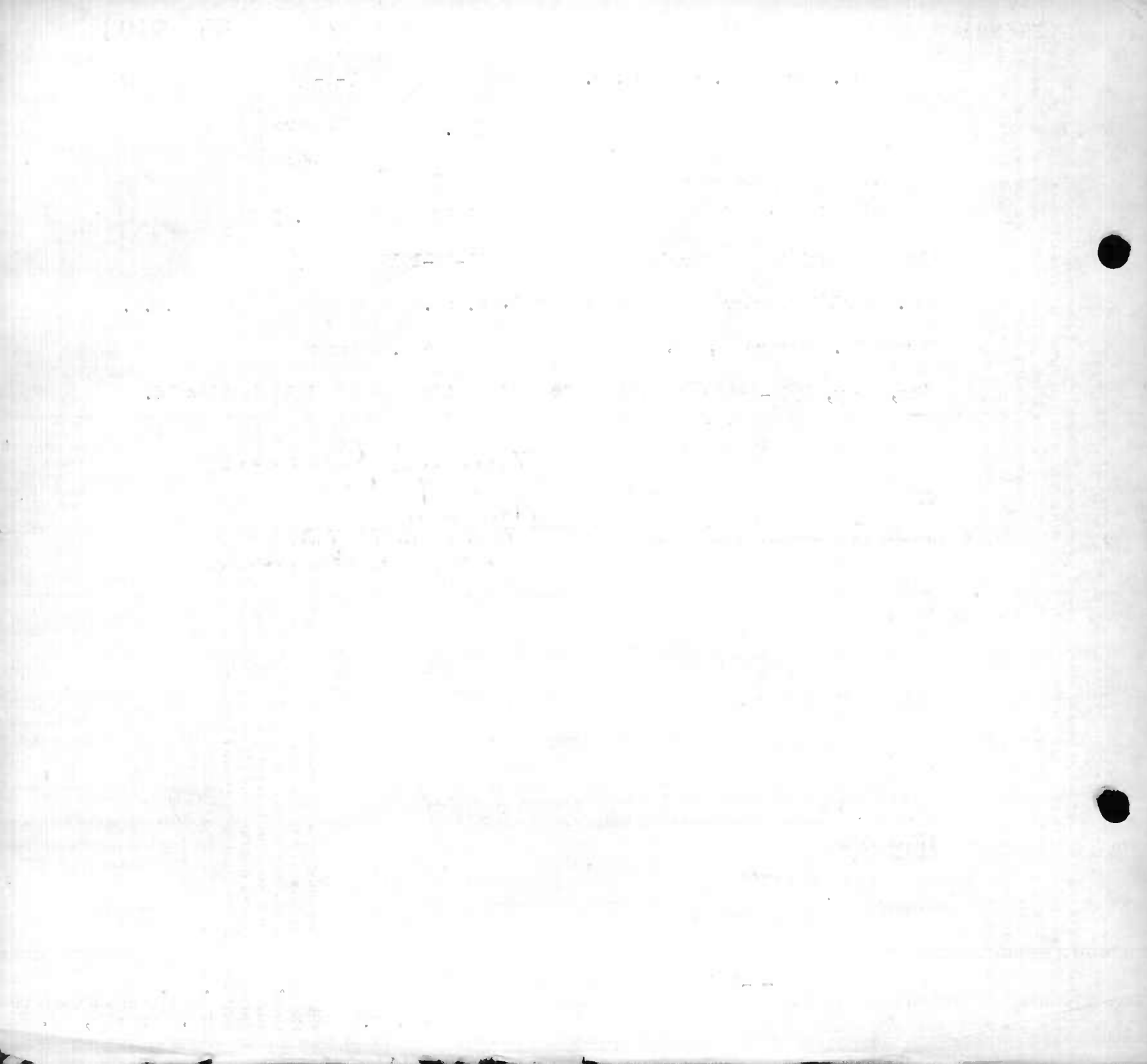
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 7103		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO.		65 7103	
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH	
(Type or Print)				Mr. Harvey B. Mussard, Jr.				7-6-65 4:25pm M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Md. B. COUNTY Baltimore					
35 Church Home & Hospital Baltimore 31, Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore Dundalk 5300	
				D. STREET ADDRESS (If rural, give location)				1917 Searles Rd. # 22	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
Male	white	Married	11-22-1919	45					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Beth. Steel Inspector			Metallurgical Dept.			W. Va.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Harvey B. Mussard, Sr.				Madge A. Johnson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes, Army, 1942-1945				23 5 26 0011		Wife		1917 Searles Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Laennec's Cirrhosis of liver					
ANTECEDENT CAUSES				(B) DUE TO Anemia					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO hemorrhage from esophageal varices					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 7 19 65 to July 7 19 65, that (I) (we) last saw the deceased alive on July 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
A. Mahum				7. 8. 65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
A. NANUM				CHURCH HOME & HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		July 9-1965		Baltimore National		Frederick Rd. Balto. Md. 21228			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR				ADDRESS	
JUL 8 1965		Robert E. Farley, M.D.		JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7104		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7104	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LEIGH. FEREBEE		2. DATE AND HOUR OF DEATH 7/6/65 11:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY V-43		C. CITY OR TOWN (If outside city limits, write RURAL and give township) NORFOLK	
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	
8. DATE OF BIRTH 6-3-95		9. AGE (In years lost birthday) 70		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk, Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME SAMUEL FEREBEE		14. MOTHER'S MAIDEN NAME MARGARET HARRELL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) Yes W.W. 1		16. SOCIAL SECURITY NO.		17. INFORMANT The Johns Hopkins Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) RESPIRATORY ARREST DUE TO (B) EMPHYSEMA AND ANEMIA DUE TO (C) MYELOID METAPLASIA		INTERVAL BETWEEN ONSET AND DEATH 15 MIN. 18 MONTHS 18 MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CONGESTIVE HEART FAILURE		1 MONTH +	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28 19 65 to July 6 19 65, that (I) (we) last saw the deceased alive on July 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen Dress Johnson				23B. DATE SIGNED July 7, 1965	
23C. PHYSICIAN'S NAME (Type) DR. ALLEN JOHNSON				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/7/1965		24C. NAME of CEMETERY or CREMATORY Elmwood	
24D. LOCATION (City, town, or county) Norfolk, Va.		24E. DATE REC'D BY HEALTH DEPT. JUL 8 1965		24F. NAME OF REGISTRAR Robert E. Farley	
24G. FUNERAL DIRECTOR Wm. J. Johnson & Son		24H. ADDRESS Baltimore, Md. 21217		24I. PA. LIC. NO.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 7105	
CERTIFICATE OF DEATH				Registered No. 65 7105	
BIRTH NO.		65 7105		2	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) McDonough, Goldie E.			2. DATE AND HOUR OF DEATH JULY 7-1965 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS Hospital			A. STATE MARYLAND B. COUNTY 28-04		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
34			D. STREET ADDRESS (If rural, give location) 406 Swann Avenue 21229		
5. SEX F.	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/25/07	9. AGE (in years last birthday) 57	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Salomons Reporting Service		11. BIRTHPLACE (State or foreign country) Baltimore, MARYLAND	
13. FATHER'S NAME William David Reaver			14. MOTHER'S MAIDEN NAME Florence M. Johnson		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213-05-5767		
			17. INFORMANT Mr. Edwin McDonough 406 Swann Avenue Baltimore, Md. 29		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I			CAUSE OF DEATH (A) Congestive heart failure (B) Athero-sclerotic Cardio-vascular disease (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from 7-5-1965 to 7-7-1965 that (I) (we) lost saw the deceased alive on 8:20 AM, 7-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gholam-Reza Pezeshkian M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-7-1965	
23C. PHYSICIAN'S NAME (Type) GHOLOM-REZA PEZESHKIAN				23D. ADDRESS 2025 W. Fayette St, Baltov, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/1965		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk. Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore County	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Wm. J. Fickner Baltimore, Md. 17	

BIRTH NO.

65 7106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Edward or Ebenezer W. Goodwin, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1965

2:20 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 N. Patterson Park Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

40 N. Patterson Park Avenue

31

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

11/1/1914

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ebenezer W. Goodwin, Sr.

14. MOTHER'S MAIDEN NAME

Roxie Boulware

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

7/7/1965

23C. NAME of CEMETERY or CREMATORY

McCall

23D. LOCATION

(City, town, or county)

(State)

Bennettsville, S. C.

24A. DATE REC'D BY HEALTH DEPT.

JUL 8

1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

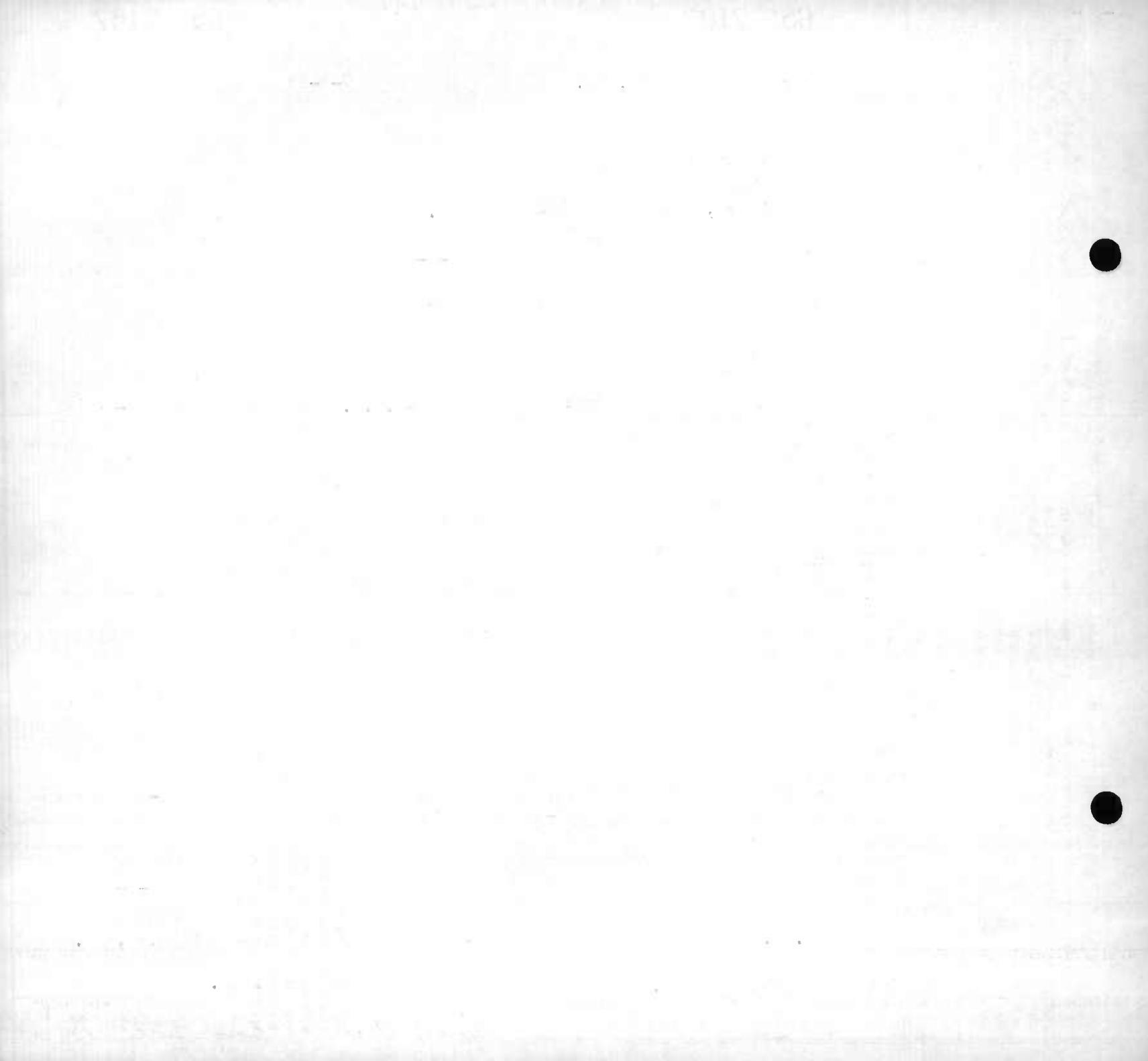
Wm. F. Fisher & Sons Balto., Md. 21217
north WPA. avos.

WALTER POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

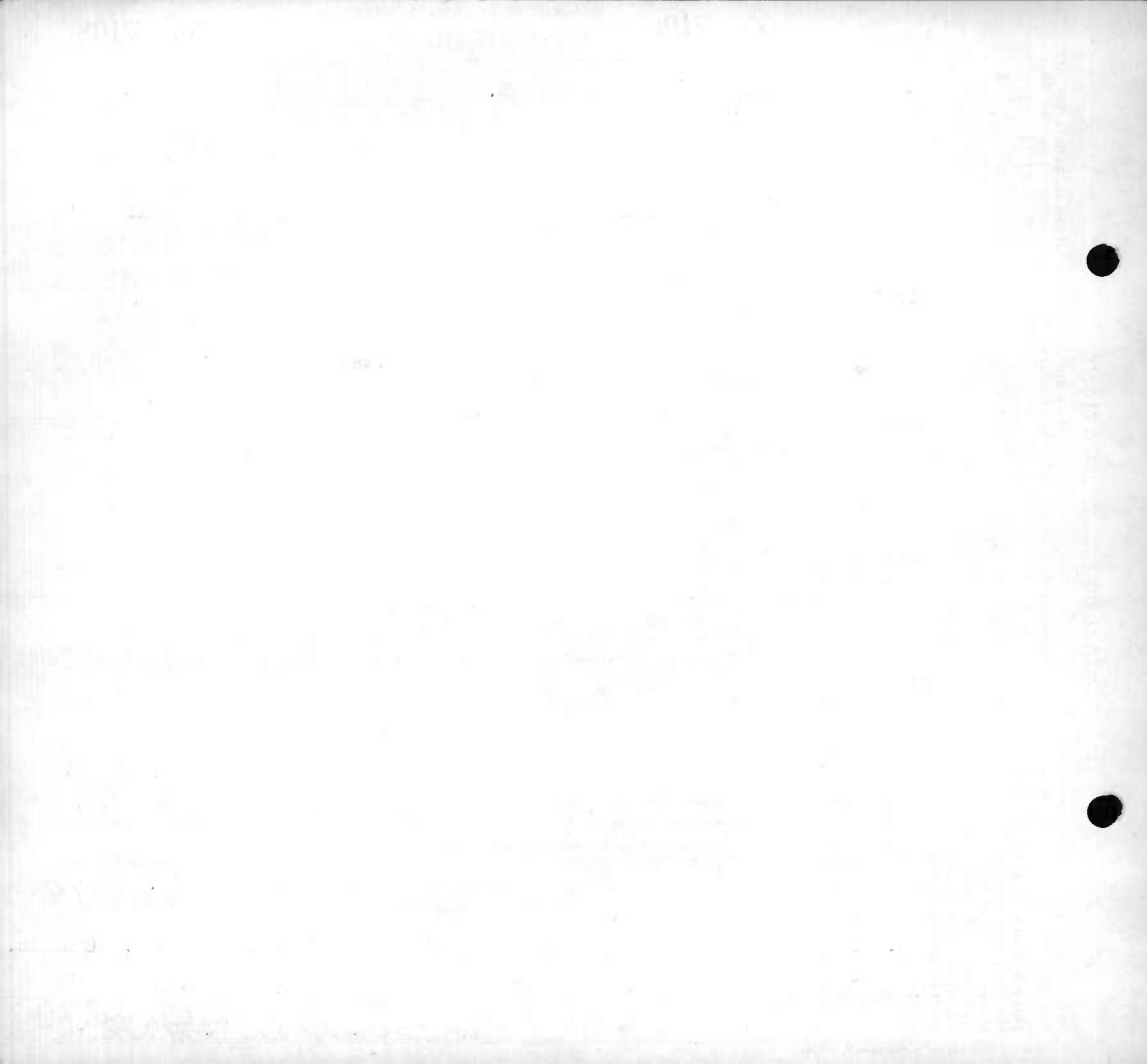
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
H-2008 65 7107		CERTIFICATE OF DEATH		65 7107	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Charles Albert Heagy, Sr.		7-6-65 7:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
31 Baltimore City Hospitals		Maryland		28-04	
4940 Eastern Avenue		C. CITY OR TOWN		Baltimore	
Baltimore, Maryland #21224		D. STREET ADDRESS		8 S. Woodington Road #21229	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	Married	10-7-82	82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Never worked				USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Heagy		Sedonia Pumphery			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No None		None		RECORDS-B.C.H. 4940 Eastern Avenue-#21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Obstructive Emphysema with Recurrent Pneumonia		years	
ANTECEDENT CAUSES		(B) Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Cardiac Arteriosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-3 19 64 to 7-6 19 65, that (I) (we) last saw the deceased alive on 7-6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		7-7-65	
Dr. H. Rathbun		BCH-4940 Eastern Avenue - Baltimore, Md.			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/9/1965		Cemetery St. Paul Evangelical Lutheran Perryman, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 8 1965		Robert E. Taylor		Wm. J. Taylor & Sons Baltimore, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7108	
BIRTH NO. 65 7108		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Galloway, Minnie B.		2. DATE AND HOUR OF DEATH 7-6-65 5:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION Keswick Home 700 West 40th Street 21211		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 700 W. 40th St. 21211	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-7-83	9. AGE (In years last birthday) 82 yrs.	10. USUAL OCCUPATION (Give kind of work) Clerk - B and O RR
10A. USUAL OCCUPATION (Give kind of work) Clerk - B and O RR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Galloway		14. MOTHER'S MAIDEN NAME Mary Jane Mercer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (R.U.) Helen Keller, 700 W. 40th St.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Coronary Sclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		cardiac Vascular Disease with right hemiplegia		11 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct. 10, 1957 to July 6, 1965, that (I) (we) last saw the deceased alive on July 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger M.D.		23B. DATE SIGNED July 7, 1965		23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/8/65		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory, Baltimore, Md.	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. FUNERAL DIRECTOR Wm. F. Fisher & Sons		24F. ADDRESS 21217	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. F. Fisher & Sons	



FUNERAL DIRECTOR: IMPORTANT

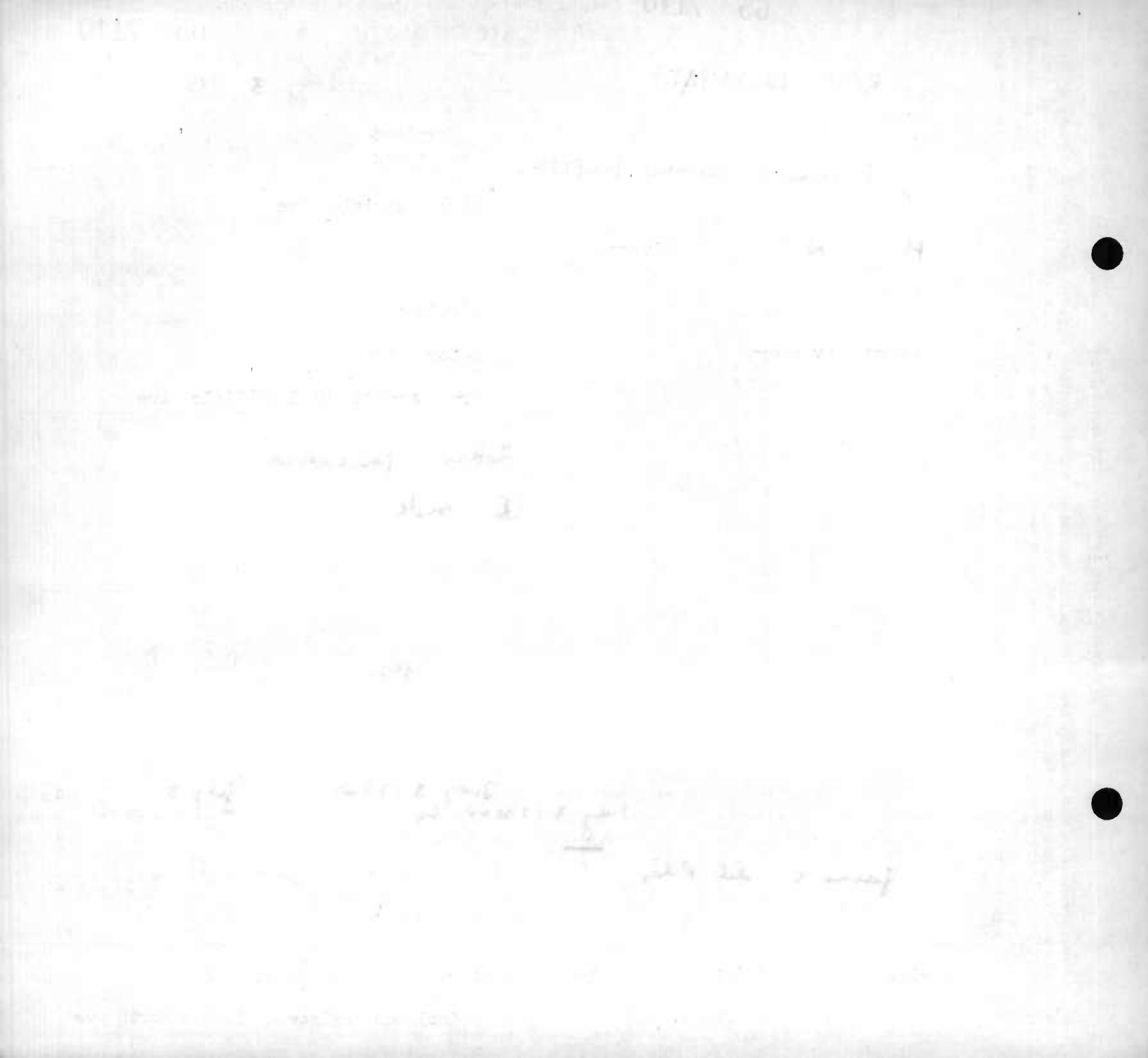
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7109	
BIRTH NO. 65 7109		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lhotsky, Frances Genevieve		2. DATE AND HOUR OF DEATH July 6, 1965 11:05 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP 44		A. STATE MARYLAND B. COUNTY 7-03			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2218 E. EAGER STREET			
5. SEX Female	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-21-88	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN KUZEL		14. MOTHER'S MAIDEN NAME ANNA PORKORNY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNK		17. INFORMANT ADDRESS MARIE TMC 2218 E. EAGER ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Septicemia			
ANTECEDENT CAUSES		(B) Osteomyelitis of vertebra			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Ulcers of stula			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Thrombosis of carotid artery L. DM NO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from July 1st 19 65 to July 6th 19 65, that (X) (we) last saw the deceased alive on July 6th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert N. Whitlock		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6 July 65	
23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-65		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION BALTO. C MID					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS FR. CVACH & SON, 9004 CHESTERS	

FUNERAL DIRECTOR: IMPORTANT

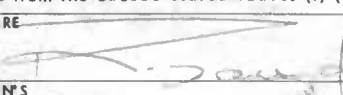
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

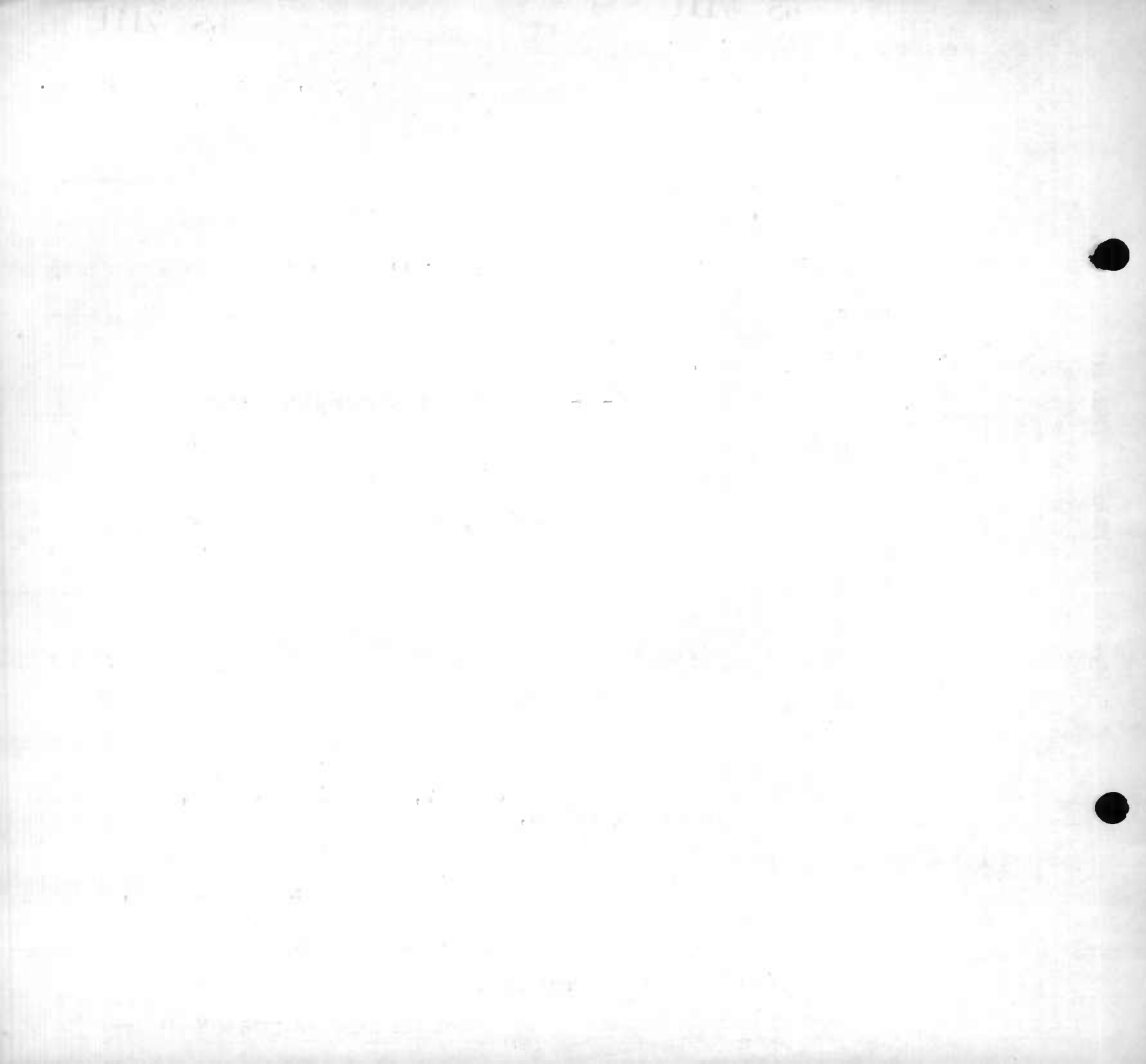
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7110	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 7110 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROY DAVENPORT			2. DATE AND HOUR OF DEATH July 3, 1965 5:30 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3401 Carlisle Ave CARLISLE		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 58	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Davenport			14. MOTHER'S MAIDEN NAME Betty Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs Durette 3401 Carlisle Ave		
18. 490 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia Ⓟ side ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 3 (3:30 a.m.) to July 3 1965 , that (I) (we) last saw the deceased alive on July 3 (3:30 a.m.) 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE James V. del Pels				23B. DATE SIGNED 7/3/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/65	24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7111				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7111	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ruth Carter				2. DATE AND HOUR OF DEATH July 4, 1965 5:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1401 Madison Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 7, ?	9. AGE (In years lost birthday) 74?	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jim Carter			14. MOTHER'S MAIDEN NAME Tillie				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-28-1746		17. INFORMANT Mr Gus Carter 1401 Madison Ave		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Hepatic Coma DUE TO (B) Primary Carcinoma of the liver DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 17, 1965 to July 4, 1965 , that (I) (we) last saw the deceased alive on July 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1965	
23C. PHYSICIAN'S NAME (Type) Andre Rigaud				23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				CERTIFICATE OF DEATH		65 7112	
1. NAME OF DECEASED (Type or Print) CHARLES WILLIAMS				2. DATE AND HOUR OF DEATH JULY 4, 1965 3⁰⁵ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL				A. STATE BALTO. MARYLAND B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 719 PARK AVE.			
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 4/6/91	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY COOK		11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID WILLIAMS				14. MOTHER'S MAIDEN NAME —			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 216 018609		17. INFORMANT Lach Rower Hospital		ADDRESS	
18. 542.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) GASTROINTESTINAL HEMORRHAGE DUE TO (B) GASTROINTESTINAL ULCERATION DUE TO (C) —				INTERVAL BETWEEN ONSET AND DEATH 26 days approx - 40 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 6/21, 6/29, 6/30		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CONTINUED BLEEDING		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (this hospital) attended the deceased from 6/8 19 65 to 7/4 19 65 , that (I) (did) last saw the deceased alive on 7/4 19 65 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Louis O. Olsen				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1965	
23C. PHYSICIAN'S NAME (Type) LOUIS O. OLSEN				23D. ADDRESS MARYLAND GEN'L HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Arlington J. Phillips		ADDRESS 1729 N. Mount	

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL

HARVEY

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1965

6:31 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3000 Ascension Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-3-15

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sand Blasting

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Harvey

14. MOTHER'S MAIDEN NAME

Annie Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

218-03-9065

17. INFORMANT

Pauline Harvey

ADDRESS

3000 Ascension Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-9-65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 8

1965

24B. NAME OF REGISTRAR

Robert E. Farwell

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 Monroe Street

ADDRESS

WALTER P. FORD

RECEIVED

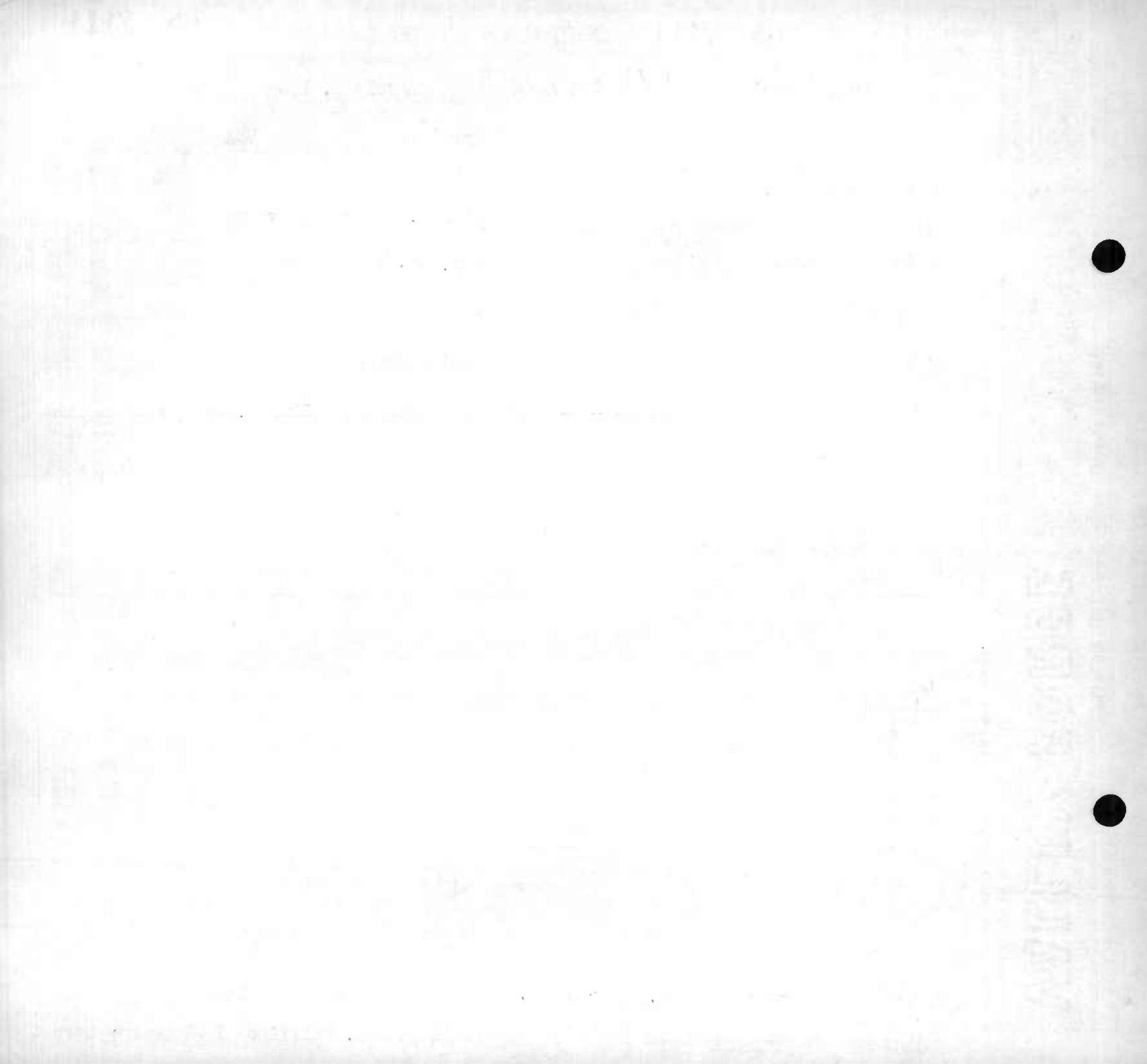
June 20th

Charles E. Ford

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

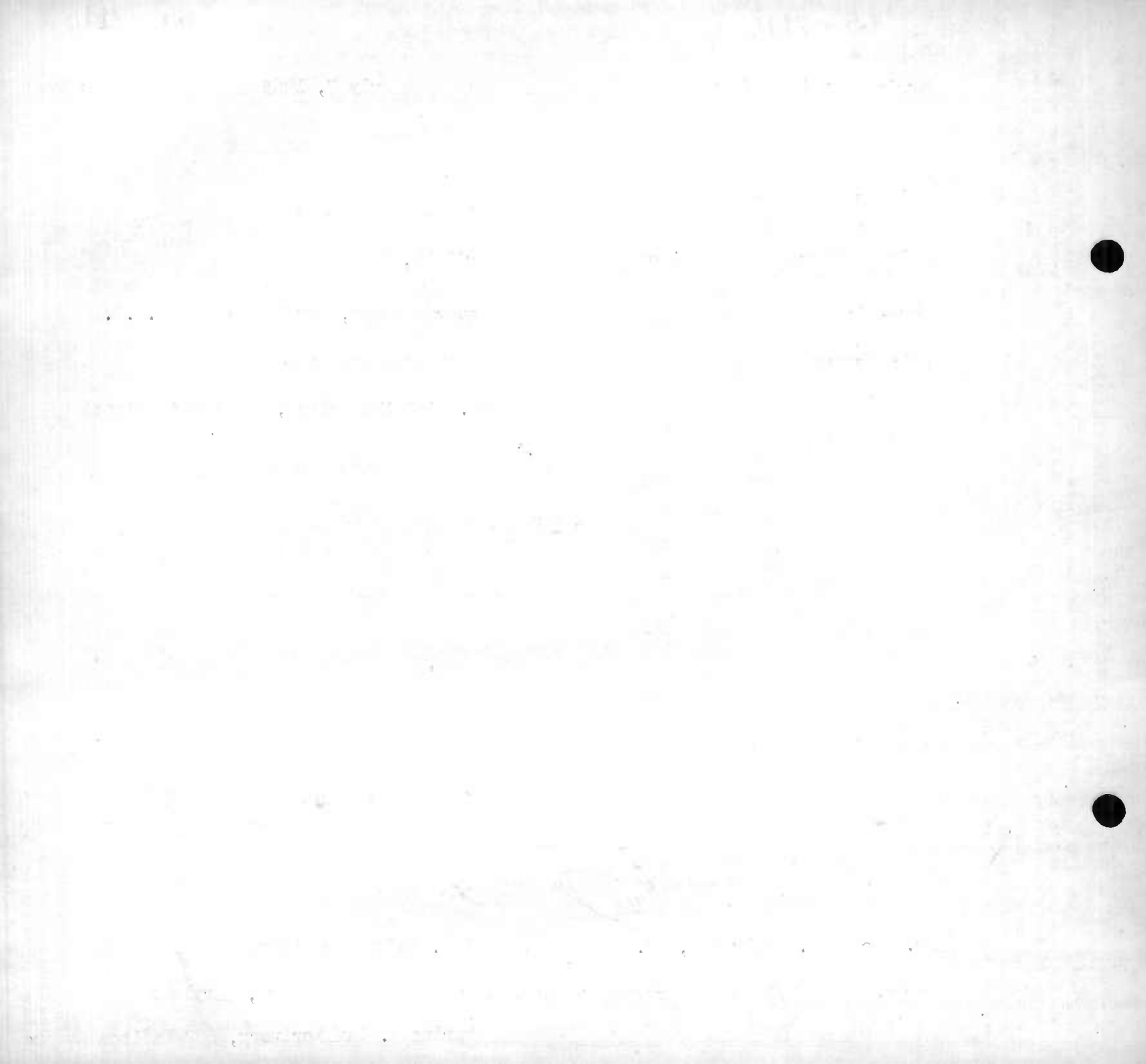
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7114	
BIRTH NO. 65 7114		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Julia Pervine (Previous)</u>		2. DATE AND HOUR OF DEATH <u>July 5, 1965</u> <u>11:12</u> <u>noon</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>oo</u> <u>1723 Lafayette Avenue</u> <u>Baltimore, Maryland 21217</u>		A. STATE <u>Maryland</u> B. COUNTY <u>USA</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1723 W. Lafayette Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept. 30, 1896</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul Sharps</u>		14. MOTHER'S MAIDEN NAME <u>Cecial Evins</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-0692D</u>		17. INFORMANT <u>Dora Cole</u> ADDRESS <u>1723 W. Lafayette Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>442X I</u> <u>CARDIOVASCULAR renal disease over 5 years</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 26, 1965</u> to <u>July 5, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John E. J. Camper</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>JOHN E. T. CAMPER</u> M.D.				23D. ADDRESS <u>639 N. Carey St., Baltimore, Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-10-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olive Bapt. Church</u>	
24D. LOCATION (City, town, or county) (State) <u>Towson Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert S. Phillips</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 Monroe Street</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7115		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7115	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Harriet Amelia Parker				July 7, 1965 6:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 Kossuth Street				A. STATE Baltimore B. COUNTY 20-07	
5. SEX Female 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow				8. DATE OF BIRTH April 12, 1877 9. AGE (in years last birthday) 88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Howard County, Maryland	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dorsey				14. MOTHER'S MAIDEN NAME Catherine Fletcher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Violetta Nelson, 38 Kossuth Street				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 I Anteroselective Cardiovascular Disease Generalized Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 15, 1954 to July 7, 1965 , that (I) lost saw the deceased alive on July 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Thomas J. Woolridge, Jr.				23B. DATE SIGNED 7-8-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 703 W. Lafayette Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 7/10/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles R. Law Mortuary, 802 Madison Avenue	



BIRTH NO.

65 7116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERKLEY WIMBER

2. DATE AND HOUR PRONOUNCED DEAD

7/6/65

6:45 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

Worcester

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Berlin

73 00

D. STREET ADDRESS (If rural, give location)

Box 114

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Elewood Wimber

14. MOTHER'S MAIDEN NAME

Rose Statton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elwood Wimber

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Intra-cranial hemorrhage

(A).....
DUE TO

A.-V. malformation of brain

(B).....
DUE TO

(C).....

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-10-65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Accomac

(State)

Va.

24A. DATE REC'D BY HEALTH DEPT.

JUL 8

1965

24B. NAME OF REGISTRAR

Robert E. Stokely

24C. FUNERAL DIRECTOR

J. H. Hensley

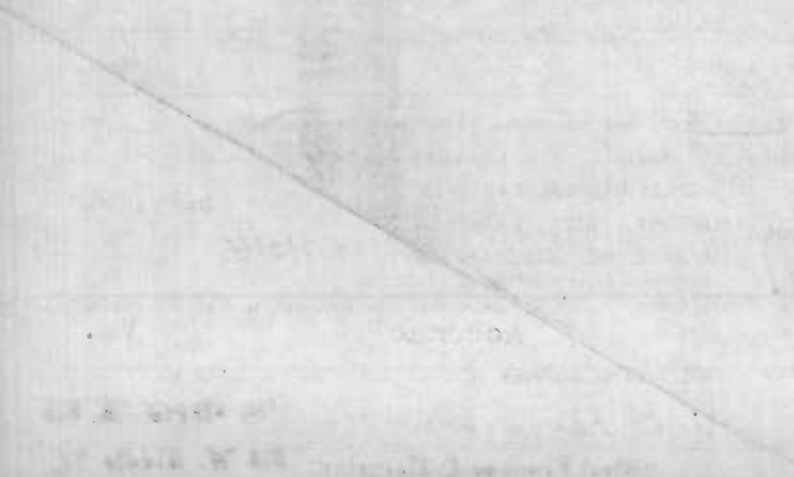
ADDRESS

38 OFFICE A 113

WALTER PROFF

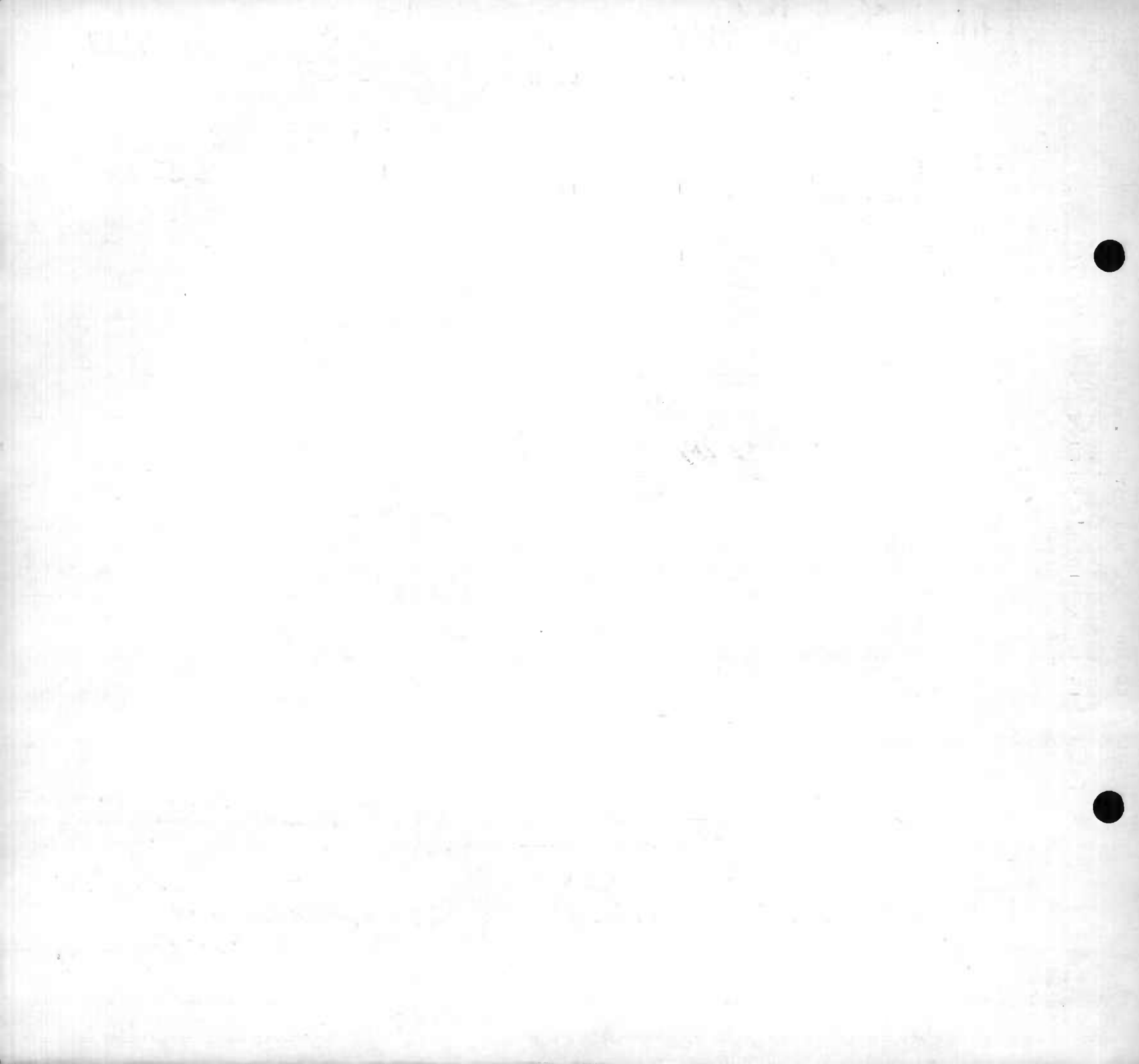
WALTER PROFF
 1000 1/2 N. 1st St.
 ST. LOUIS, MO.
 63102

WALTER PROFF



RELEASED ON APPROVAL BY DR. CENDANA OF
FUNERAL DIRECTOR: IMPORTANT
THE MEDICAL EXAMINER'S OFFICE
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

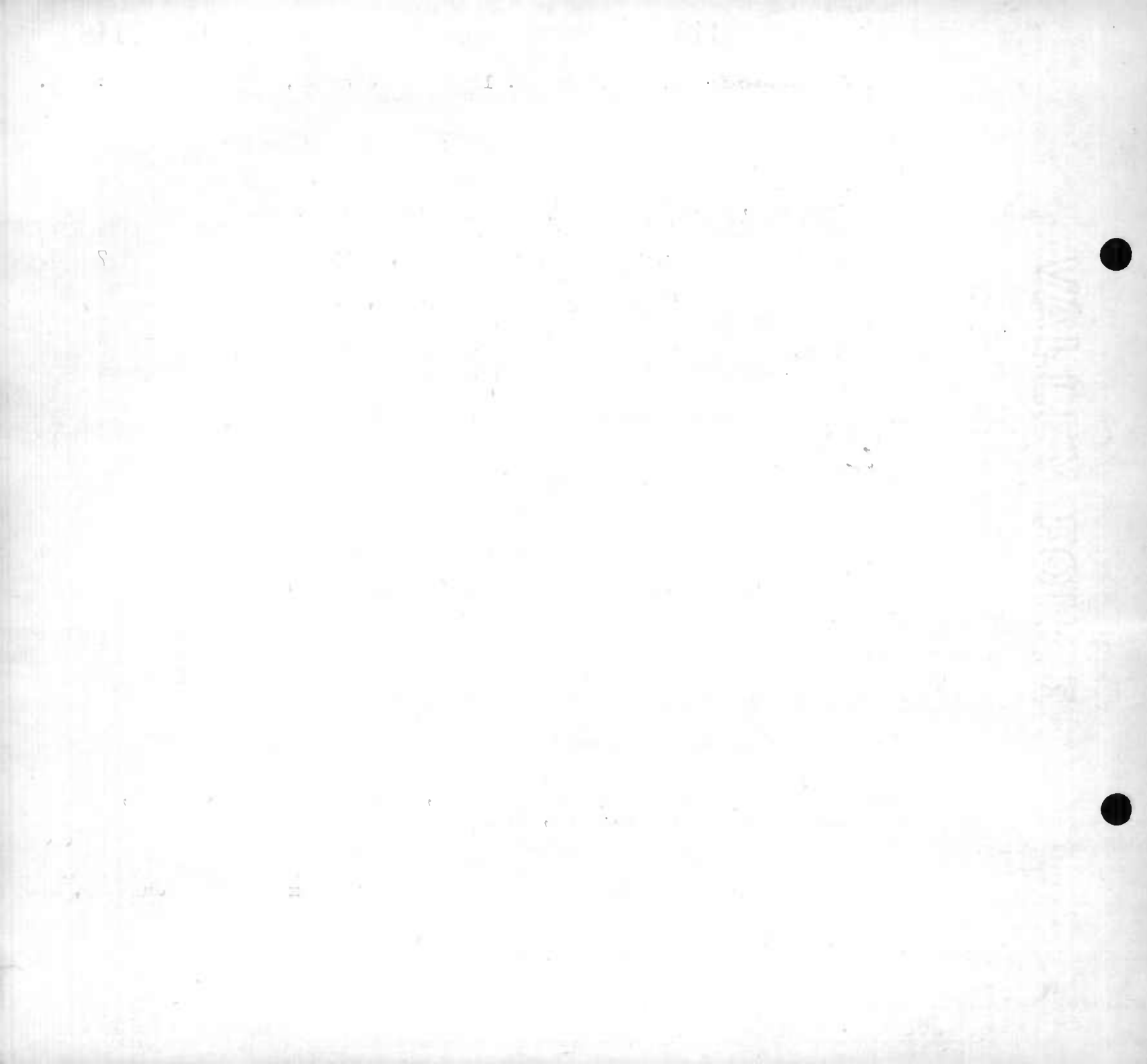
BIRTH NO. <i>65 7117</i>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <i>65 7117</i>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>JEAN SHELTON</i>		2. DATE AND HOUR OF DEATH <i>6-28-65 11:25 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHN S HOPKINS HOSPITAL</i>		A. STATE <i>MARYLAND</i> , B. COUNTY <i>MONTGOMERY</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>MONROVIA 65-00</i>			
		D. STREET ADDRESS (If rural, give location)			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>6/21/64</i>	9. AGE (In years last birthday) <i>1</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA SHELTON</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>754.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CONGENITAL HEART DIS:</i> <i>1) PATENT DUCTUS ARTERIOSIS</i> <i>2) A-V COMMUNIS</i> <i>3) PATENT FORAMEN OVALE</i> <i>4) PSEUDO TRUNCUS ARTERIOSUS</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>MONGOLISM</i>		CAUSE OF DEATH <i>CONGENITAL HEART DIS:</i> <i>1) PATENT DUCTUS ARTERIOSIS</i> <i>2) A-V COMMUNIS</i> <i>3) PATENT FORAMEN OVALE</i> <i>4) PSEUDO TRUNCUS ARTERIOSUS</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 YR</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>JUL 28 1965</i> , that <i>AT</i> (we) last saw the deceased <i>the</i> on <i>DOA JUNE 28 1965</i> and that in <i>(our)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>AT</i> (We) (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>William D. Heizer</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/30/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>WILLIAM D. HEIZER</i>		23D. ADDRESS <i>826 N. BROADWAY BALTIMORE, MARYLAND</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>JUL 2 1965</i>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <i>ANATOMY BOARD OF MARYLAND</i>	
24D. LOCATION		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

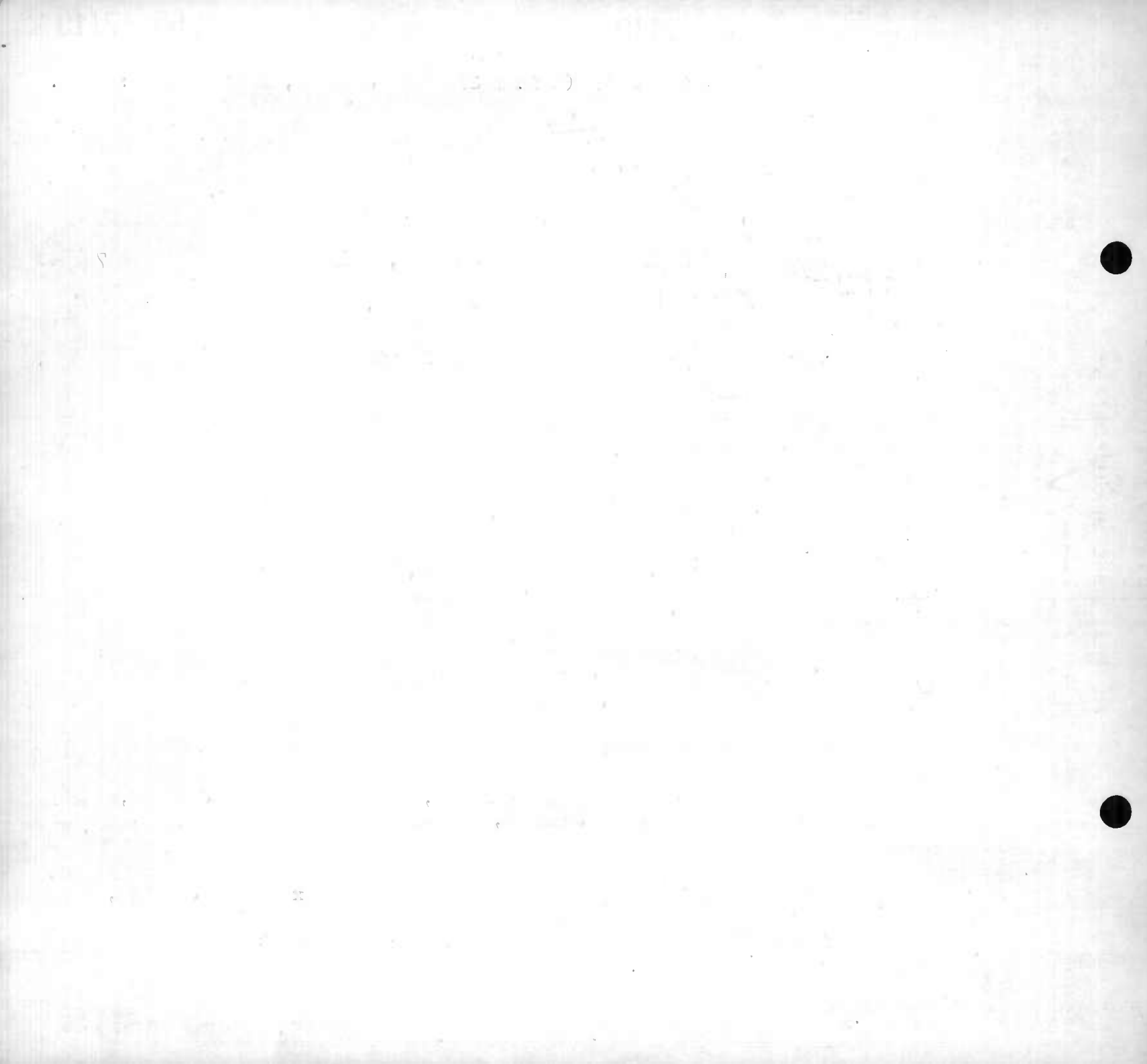
BIRTH NO. 65-15394		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65-7118	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Baby Mollie Sterns (twin No. 1)		June 28, 1965 8:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
39 Provident Hospital 1514 Division Street Baltimore, Maryland		Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		15-13	
		D. STREET ADDRESS (If rural, give location)			
		2500 Quantico Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negro	Single	June 28, 1965		7 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?		USA			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Roland Sterns			Mollie Winstead		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO					
(B) DUE TO		Tumour (1303)		8 hrs	
(C) UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Twin birth			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 28, 1965 19 to June 28, 1965, that (I) (we) last saw the deceased alive on June 28, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vincent R. Blake M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 30, 1965	
23C. PHYSICIAN'S NAME (Type) Vincent Blake		23D. ADDRESS M.D. 1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUL 2 1965		24C. NAME OF CEMETERY OR CREMATORY	
				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Farkley		25C. FUNERAL DIRECTOR ADDRESS	
				MORTUARY SERVICE - BCHO	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 7119		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7119	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
(Type or Print)		Baby John Mollie Sterns (twin # 2)		June 28, 1965		8:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Maryland			
39 Provident Hospital		1514 Division Street		Baltimore		15-13	
Baltimore, Maryland		2500 Quantico Avenue		O. STREET ADDRESS		(If rural, give location)	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	Negro	Single	June 28, 1965		7		40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Baltimore, Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Roland Sterns		Mollie Winstead					
17. INFORMANT		ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO					
ANTECEDENT CAUSES		(B) DUE TO		Tumourity (12/07)		8 hrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		Twin birth			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from June 28, 1965 to June 28, 1965		that (I) (we) last saw the deceased alive on June 28, 1965		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED					
Vincent Blake		June 30, 1965					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Vincent Blake		1514 Division Street					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY & CREMATORY		24D. LOCATION (City, town or county)		(State)	
JUL 2 1965		ANATOMY BOARD OF MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1965	Robert E. Farkley, M.D.			MORTUARY SERVICE - BCHB			



65 7120

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 7120

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VERONICA C. TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

7/6/65 7:30 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

41 St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #6

D. STREET ADDRESS (If rural, give location)

5419 Radecke Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 23, 1930

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Richard J. Taylor Sr.

14. MOTHER'S MAIDEN NAME

Elizabeth D. Bliz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-26-0679

17. INFORMANT

ADDRESS

Lawrence Taylor 4815 Truesdale Ave.

18.

E970.3 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Overdose of salicylates

8/6/65

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Fractures of spine and right leg

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

5419 Radecke Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 6 65 5:35a.

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒21F. HOW DID INJURY OCCUR? apparently took over-
dose and fell from height

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/10/65. Holy Redeemer Cemetery

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 8 1965

24B. NAME OF REGISTRAR

Robert E. Fairley

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. 14 Md.

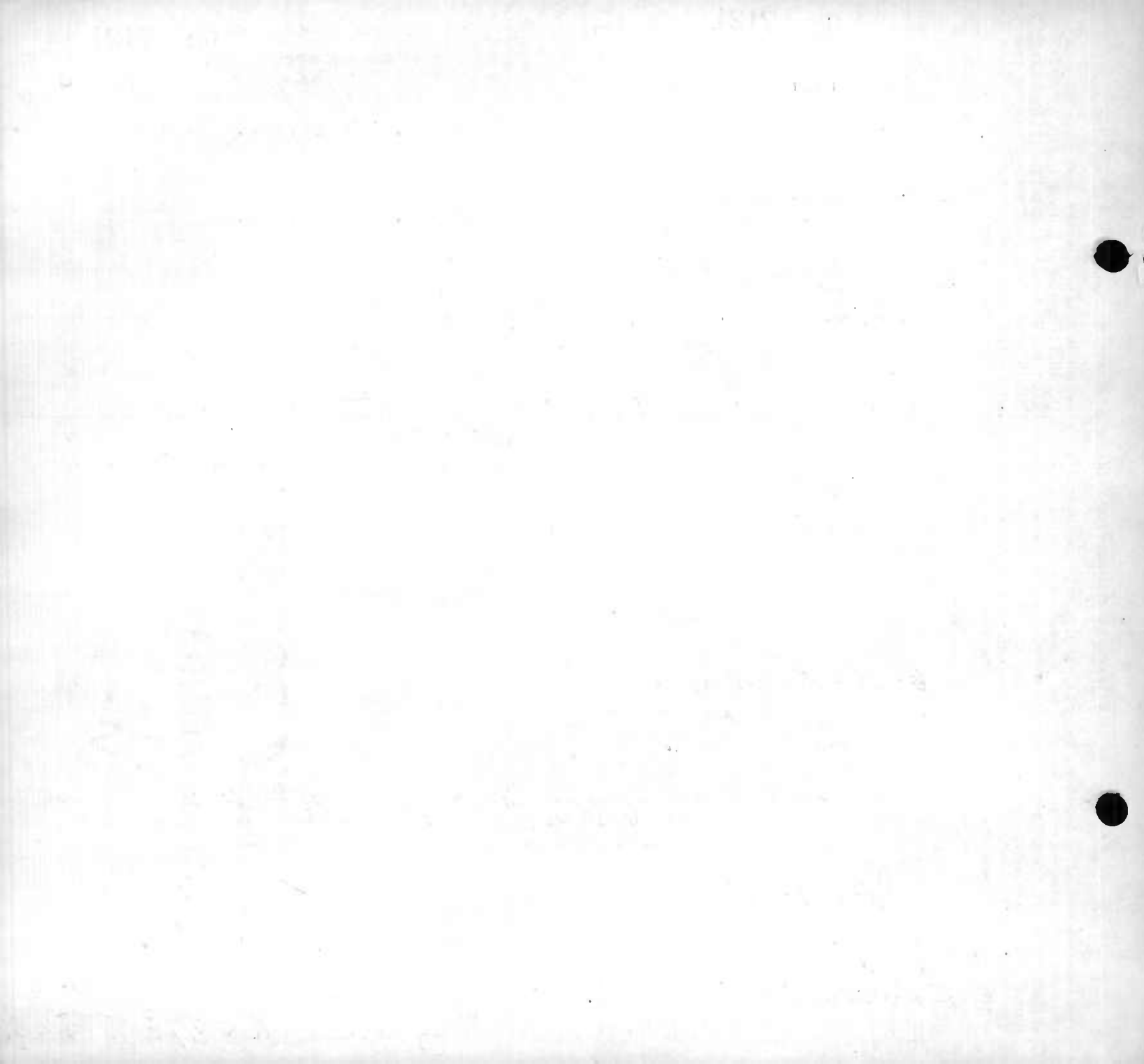
ADDRESS

VALLEY PRINCIPLE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7121				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7121	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				WILLIE LAWRENCE		6/30/65 6:30 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
33 JOHNS HOPKINS HOSPITAL				MARYLAND			
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
MALE				NEGRO		WIDOWER	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
For Tea						12-14-04	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		9. AGE (In years lost birthday)	
RAYNOR LAWRENCE				SARAH BLACK		61	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				21809 7024		Hospital Record	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CARCINOMA OF ESOPHAGUS WITH TRACHEO ESOPHAGEAL FISTULA		> 2 MONTH	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6-29-65				CARCINOMA OF ESOPHAGUS			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 6-14 1965 to 6-30 1965, that (I) (we) lost saw the deceased alive on 6-30-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
John D. Harrah						6-30-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN D. HARRAH				M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				7-3-65		Mt Calvary Cem	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1965				R. E. F. F. F.		R. E. F. F. F.	
						ADDRESS	
						217 E. Preston St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7122	
BIRTH NO. 65 7122		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TREGLIA, Gertrude Mary		2. DATE AND HOUR OF DEATH 7-7-65 10420 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital		A. STATE Maryland B. COUNTY Harford			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bel Air 62-32			
		D. STREET ADDRESS (If rural, give location) 7 East Ring Factory Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 13, 1925	9. AGE (In years last birthday) 40	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10B. KIND OF BUSINESS OR INDUSTRY Chemical Industry		11. BIRTHPLACE (State or foreign country) Milton, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph P. Murphy		14. MOTHER'S MAIDEN NAME Gertrude V. Concannon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-14-8645		17. INFORMANT (Husband) 838-4416 ADDRESS 7 East Ring Factory Rd, Bel Air, Maryland 21014	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma @ breast & metastasis to bone.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1961-1965	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0-1961		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of @ breast		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 6-23 19 65 to 7-7 19 65 , that (II) <u>(we)</u> last saw the deceased alive on 7-6- 19 65 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE Eldon S. Hawbaker M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-7-65	
23C. PHYSICIAN'S NAME (Type) ELDON S. Hawbaker		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 9, 1965	24C. NAME OF CEMETERY or CREMATORY St. Ignatius Cath. Church Cemetery		24D. LOCATION (City, town, or county) (State) Hickory, Harford Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR Joseph William Fester ADDRESS W. Broadway	

181

7-7-62 11:20 AM TIGER, LACONIA, N.H.

1000 ft. alt.

March 1962

1000 ft. alt.

1000 ft. alt.

1000 ft. alt.

1000 ft. alt.

1000 ft. alt.

Continuation of 1000 ft. alt.

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1000 ft. alt.

7-7-62

x

March 1962

1000 ft. alt.

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BIRTH NO. 65 7123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
BELFIELD BURNETT		7/6/65 6:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
34 Bon Secours Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-02	
		D. STREET ADDRESS (If rural, give location) 2544 W. Fayette St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
male	colored	Single	Aug-4-1902
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
63		Retired	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
British West Indie			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Haydreon Burnett		Elizabeth Burnett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No			
17. INFORMANT		ADDRESS	
Mr. Deighton O. Edwards.		230-02 139th ave. Laurelton, 13, NY	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
D			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
no			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
Rudiger Breitenecker, M.D.		DATE SIGNED 7/7/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		7/10/65	
23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Woodlawn Cemetery		New York, City	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
JUL 8 1965		Robert E. Jank...	
24C. FUNERAL DIRECTOR		ADDRESS	
The Morton and Dyett Fun'l Home		1701 Laurens St. Balto, Md. 21217	

FUNERAL DIRECTOR: IMPORTANT

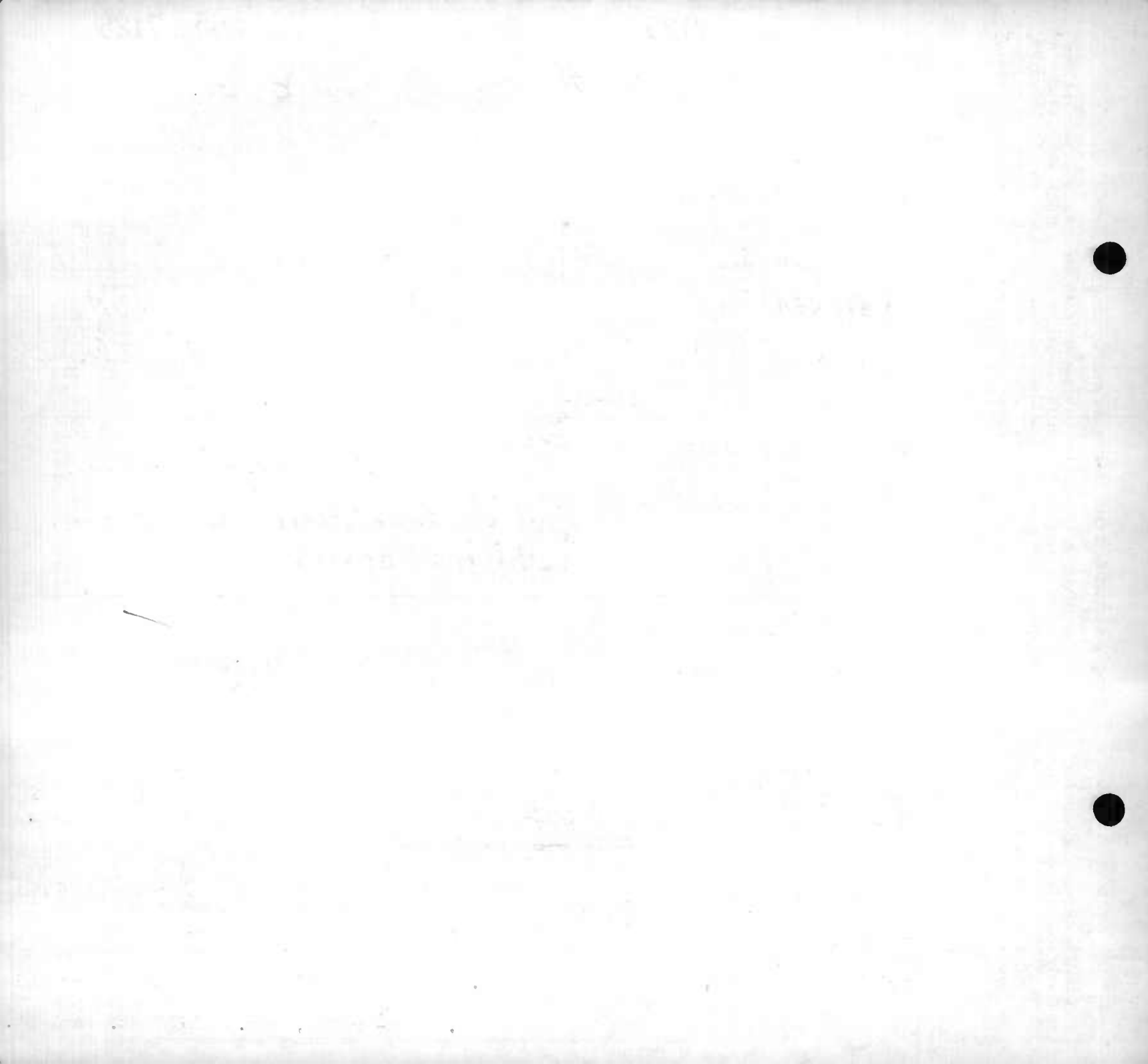
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 7124	
BIRTH NO. 65 7124		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE H. BIRCKHEAD		2. DATE AND HOUR OF DEATH 7-6-65 10:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
33 THE JOHNS HOPKINS HOSPITAL		BALTIMORE		800 N. STREEPER ST.	
6. SEX MALE	7. RACE WHITE	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	9. DATE OF BIRTH 5-17-86	10. AGE (In years lost birthday) 79	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cutler		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME STEVEN Birkhead		14. MOTHER'S MAIDEN NAME FLORENCE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 214-01-7250		17. INFORMANT ADDRESS Mrs. Sadie Birkhead 800 N. Streeper St	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral vascular occlusion DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 4 days		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2 19 65 to 7-6 19 65 , that (I) was last saw the deceased alive on 7-6 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE Asbury T. Hass		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) DR. A. T. HASSE		M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/65		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) Eastern Avenue					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Finken		25C. FUNERAL DIRECTOR ADDRESS Frederick D. Miller Inc 3019 EE. Monument St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7125	
BIRTH NO. 65 7125		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EATON, THOMAS A. SR.		2. DATE AND HOUR OF DEATH July 6, 1965 1:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 7-01			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3812 EDNOR RD.			
5. SEX M	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) MARRIED	8. DATE OF BIRTH 2/8/94	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Clinton Eaton			14. MOTHER'S MAIDEN NAME Nellie Vandergriff Evans		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-1143		17. INFORMANT Mrs. O. Olsen ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) 572.2 I PELVIC PERITONITIS		CAUSE OF DEATH PELVIC PERITONITIS (A) PELVIC ABSCESS DUE TO PELVIC ABSCESS (B) CHRONIC COLITIS DUE TO CHRONIC COLITIS (C) CHRONIC COLITIS		INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3/6/30/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Colitis, ulcerative		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work <input type="checkbox"/> A Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (1) (this hospital) attended the deceased from July 3, 1965 to July 6, 1965 , that (I) (—) last saw the deceased alive on July 6, 1965 and that (In (—) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (—) (did not) view the body after death.					
23A. SIGNATURE Mrs. O. Olsen		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 6, 1965	
23C. PHYSICIAN'S NAME (Type) LOUIS O. OLSEN		M.D. MD. GEN'L HOBB		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 10, 65	24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore County Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7126		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7126	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Willie HARVEY		
2. DATE AND HOUR OF DEATH 7-2-65 3:15 P.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 George Washington CARVER NURSING Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY La Plata		
5. SEX MALE 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED MARRIED			8. DATE OF BIRTH Aug 6, 1894 9. AGE (In years last birthday) 71		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10B. KIND OF BUSINESS OR INDUSTRY TRUCK FARMING		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM HARVEY			14. MOTHER'S MAIDEN NAME Nellie HARVEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT CHART # 716			ADDRESS 607 Penna Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, osthenia, etc. It means the disease injury or complication which caused death.)			M.D. CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			3/8/65		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from April 26, 1965 to July 2, 1965 , that (I) (we) last saw the deceased alive on July 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. N. Mac MURCHY M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) J. N. MAC MURCHY M.D.			23D. ADDRESS 500 E Madison St.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 7, 1965		24C. NAME OF CEMETERY or CREMATORY ST. IGNATIUS CEMETERY	
24D. LOCATION (City, town, or county) (State) St. THOMAS MANOR, BEL ALTON, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS EDGAR L. LYNCH, 2463 DRUID HILL AVE-21217			

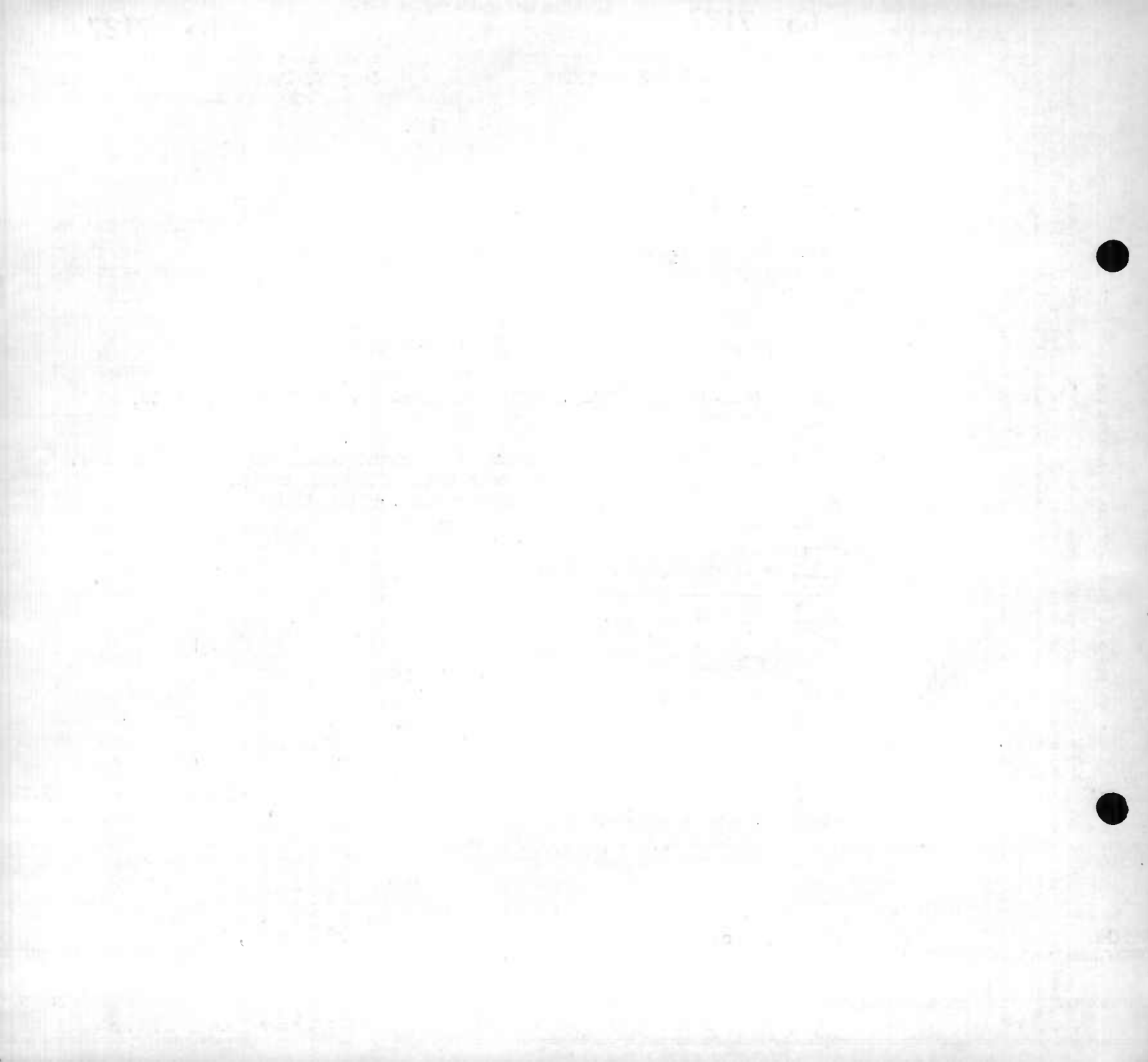


GB

VS 150-REV. 1/1/65

BIRTH NO.						BALTIMORE CITY HEALTH DEPARTMENT						Registered No.											
M.E. CASE NO.						CERTIFICATE OF DEATH						65 7127											
1. NAME OF DECEASED (Type or Print)												2. DATE AND HOUR OF DEATH											
WILLIAM CLIMMON DAVENPORT												July 7, 1965 2:10 A M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND												4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)												A. STATE B. COUNTY											
US Public Health Service Hospital Wyman Pk. Drive & 31st Street												Md. 15-01											
												C. CITY OR TOWN (If outside city limits, write RURAL and give township)											
												Baltimore											
												D. STREET ADDRESS (If rural, give location)											
												1401 Calhoun Street											
5. SEX			6. RACE			7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH			9. AGE (In years lost birthday)			10. If Under 1 Yr. Months Days			11. If Under 24 Hrs. Hours Min.					
M			col			Single			6/22/22			43											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
laborer												NC						USA					
13. FATHER'S NAME												14. MOTHER'S MAIDEN NAME											
Webb Simpson												Mattie Davenport											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS											
yes USA 1946-1948						224-16-4449						Records- US PHS Hospital, Balto, Md.											
18. CAUSE OF DEATH												INTERVAL BETWEEN ONSET AND DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH												Carcinoma of right tonsillar											
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)												(A) DUE TO fossa with extension to the tongue and peritonsillar tissues											
ANTECEDENT CAUSES												(B) DUE TO											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.												(C)											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																							
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED						20A. AUTOPSY? (Yes or No)						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
												yes											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)						21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.)						21E. INJURY OCCURRED						21F. HOW DID INJURY OCCUR?											
(Month) (Day) (Year) (Hour)						While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>																	
22. I certify that (I) (this hospital) attended the deceased from Mar. 24 19 65 to JULY 7 19 65 that (I) (we) last saw the deceased alive on July 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																							
23A. SIGNATURE												23B. DATE SIGNED											
Thomas Lau M.D.												7/7/65											
23C. PHYSICIAN'S NAME (Type)												23D. ADDRESS											
Thomas J. Lau, Surgeon (R)												US PHS Hospital, Balto, Md.											
24A. BURIAL CREMATION, REMOVAL (Specify)						24B. DATE						24C. NAME of CEMETERY or CREMATORY						24D. LOCATION (City, town, or county) (State)					
Burial						7-9-65						Baltimore Cat						Baltimore					
25A. DATE REC'D BY HEALTH DEPT.						25B. NAME OF REGISTRAR						25C. FUNERAL DIRECTOR						ADDRESS					
JUL 8 1965						P. E. E. Farber						Chas. W. Brown						1000 Biscuit St					

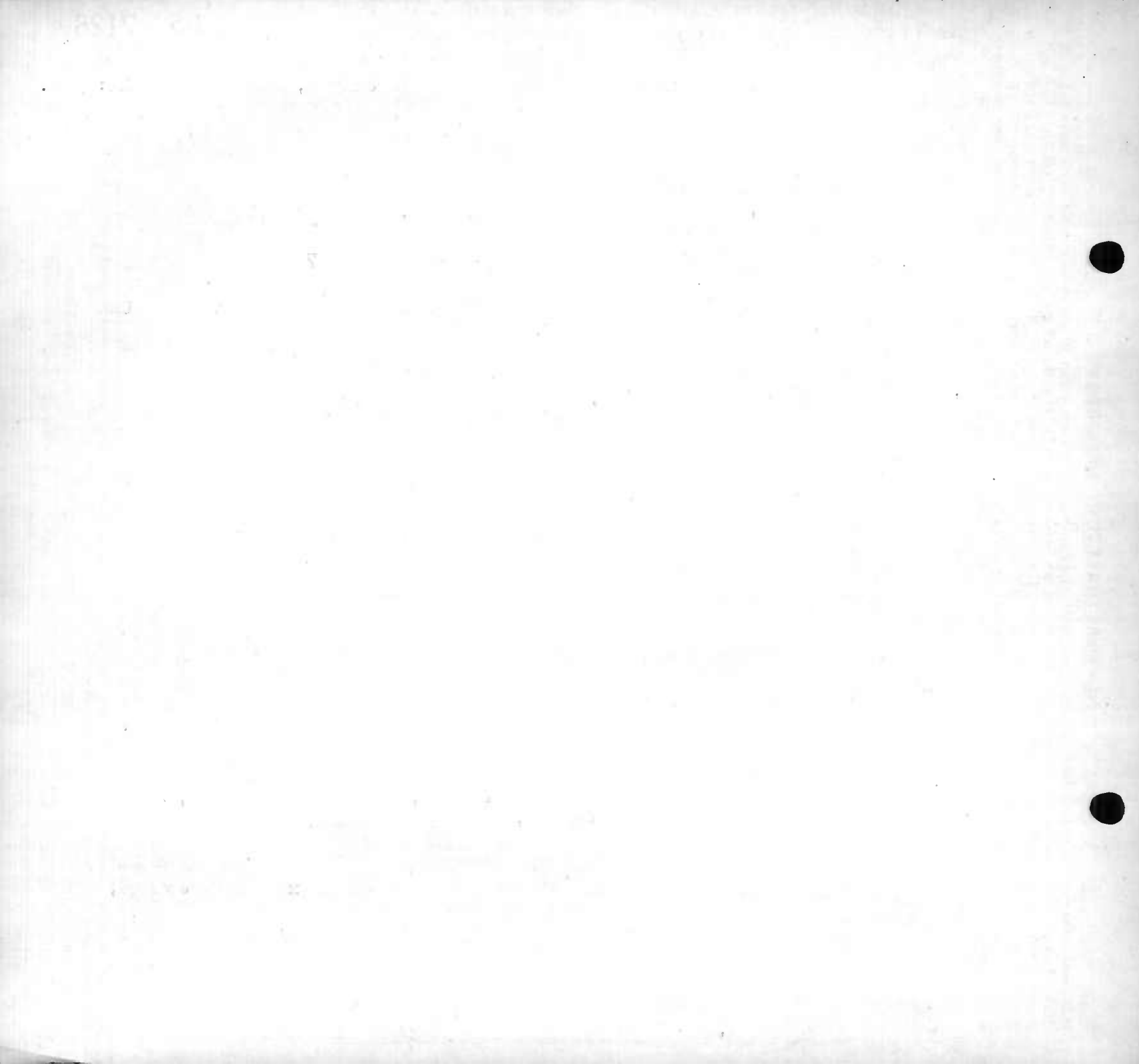
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

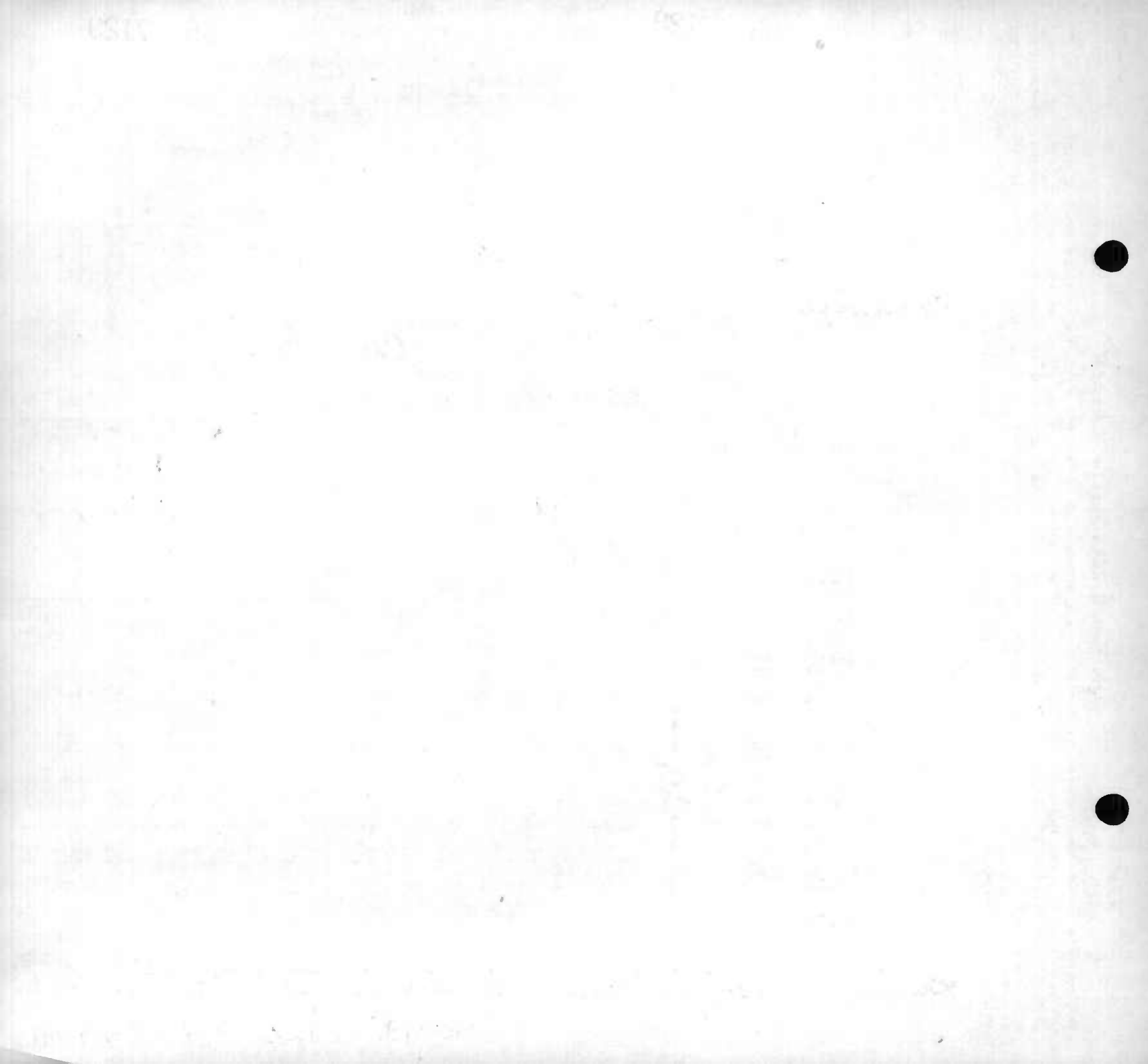
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7128	
BIRTH NO. 65 7128		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Carrie Tolliver		2. DATE AND HOUR OF DEATH July 5, 1965 11:25 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 1514 Division Street Baltimore, Maryland		A. STATE Maryland B. COUNTY 15-01			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1444 N. Carey Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-21-1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dennis Bailey		14. MOTHER'S MAIDEN NAME Marionda Boyer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT William Smith	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 157X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Pancreas DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 4, 19 65 to July 5, 19 65 , that (I) (we) lost saw the deceased alive on July 5, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alvin Thompson				23B. DATE SIGNED July 6, 1965	
23C. PHYSICIAN'S NAME (Type) Alvin Thompson				23D. ADDRESS 1514 Division Street	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-9-1965		24C. NAME of CEMETERY or CREMATORY Carmel	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1965		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR Shirley O. Wilson		25D. ADDRESS 1001 Beauty St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

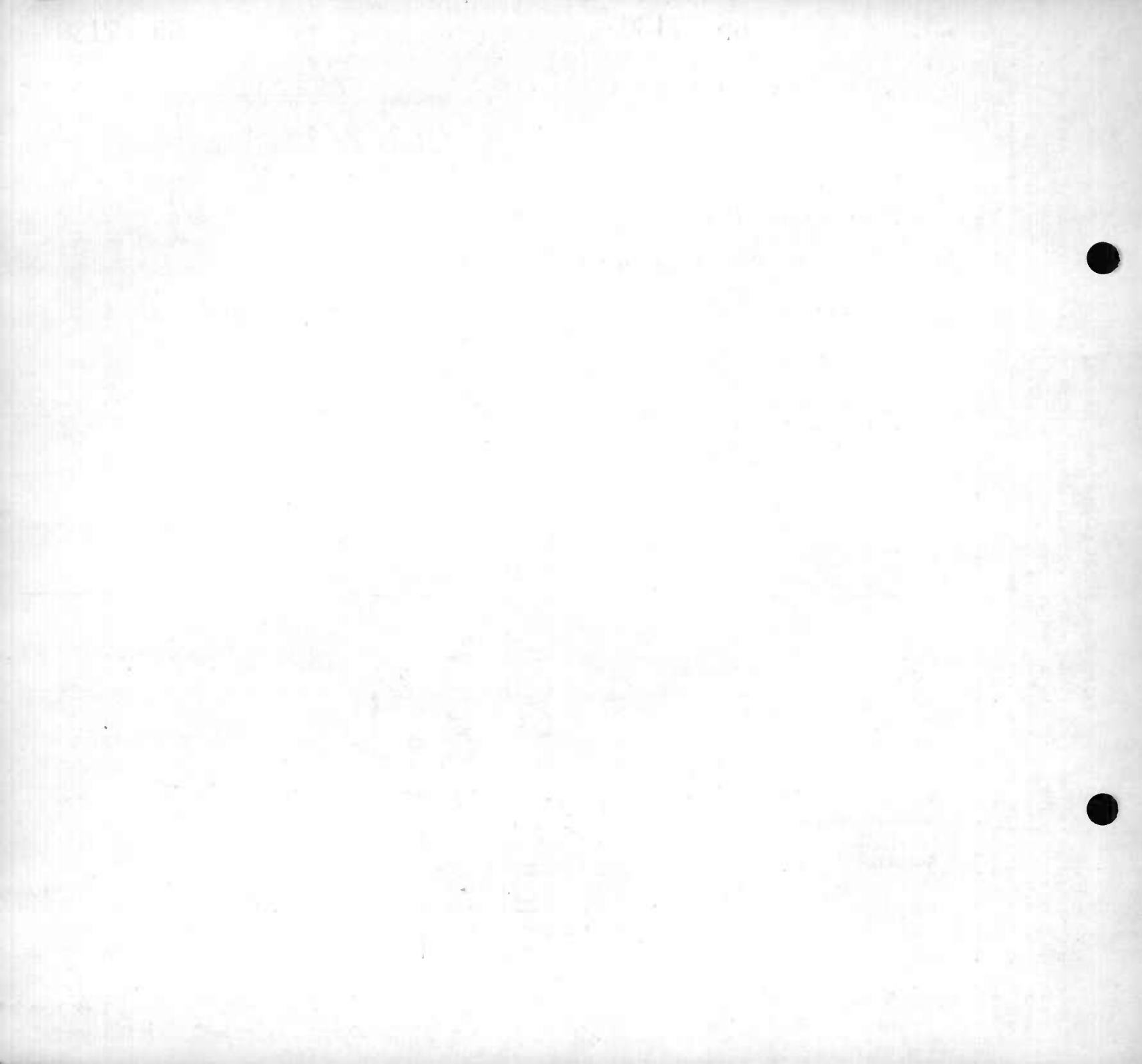
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 7129		CERTIFICATE OF DEATH				Registered No. 65 7129			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Roberts, Geneva Gladys</i>				2. DATE AND HOUR OF DEATH <i>7/2/65 8:15 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>						A. STATE <i>Md.</i>			
						B. COUNTY <i>13-04</i>			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. 17</i>			
						D. STREET ADDRESS (If rural, give location) <i>1710 Gwynns Falls Pkwy.</i>			
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>5/8/15</i>	9. AGE (In years last birthday) <i>50</i>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Corsey</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-14-1642</i>		17. INFORMANT <i>R. Stoner</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>1010X1</i>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
				(A) TUBERCULOUS MENINGITIS DUE TO				1 Month	
				(B) Miliary TB of Lungs DUE TO				1 Month	
				(C)					
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>7/1/65</i> to <i>7/2/65</i> that (I) (we) last saw the deceased alive on <i>7/2/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Robert E. Stoner, M.D.</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/2/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert E. Stoner, M.D.</i>						23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Westport (Baltimore) Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Stoner, M.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph L. Ram</i>		ADDRESS <i>2222 W. North Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

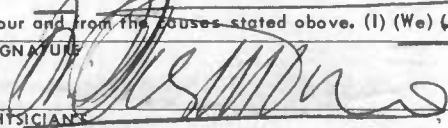
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

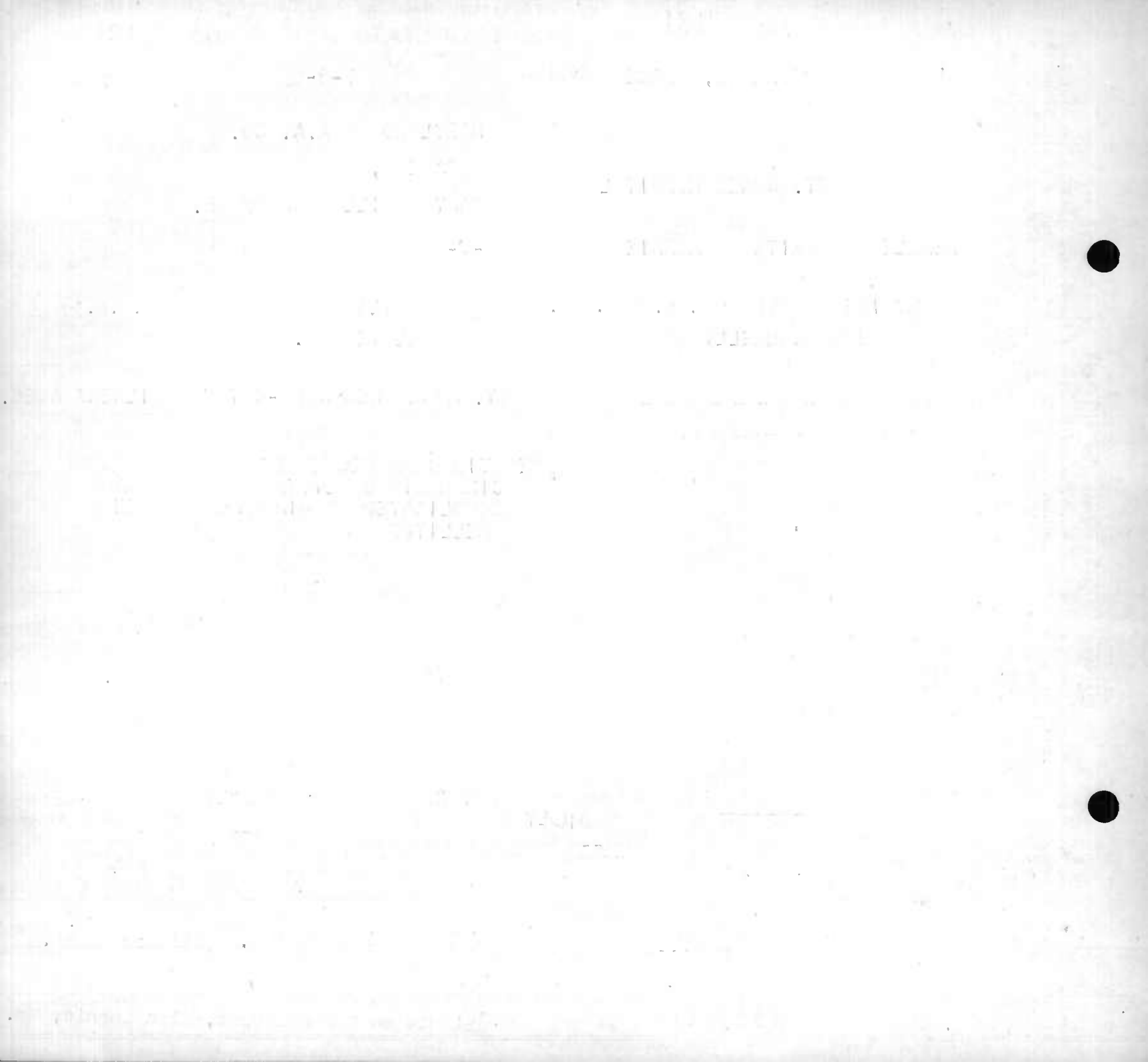
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 7130</u>	
BIRTH NO. <u>65 7130</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Bessie Burke</u>		2. DATE AND HOUR OF DEATH <u>7-5-65</u> <u>5:00 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 George Washington</u> <u>CARVER Nursing Home</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>16-83</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>703 N Mount St.</u>			
5. SEX <u>Female</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MARCH 20-1882</u>	9. AGE (In years last birthday) <u>93</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Chart # 663 607 Penna. Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4221 I</u> (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <u>Cerebrovascular accident</u> DUE TO (B) <u>Arterio-sclerotic changes</u> DUE TO (C) <u>vascular changes</u> <u>2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0 /</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> <u>1964</u> to <u>7/5</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>7/5/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.					
23A. SIGNATURE <u>J.N. Mac Murety</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>July 5/65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>500 E Madison St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>03</u>		24B. DATE <u>7/8/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>St Thomas</u>	
24D. LOCATION (City, town, or county) (State) <u>Rg dylston Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Jarky</u>		25C. FUNERAL DIRECTOR <u>Conan men Chapel 512 N Camille</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7131	
BIRTH NO. 65 7131		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FURHMAN, GRACE Evelyn		2. DATE AND HOUR OF DEATH 7-6-65 3:36A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY A.A. CO. 52-00			
40 ST. AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA,			
		D. STREET ADDRESS (If rural, give location) GARY & WILLOW BROOK DR.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, DIVORCED, OR WIDOWED (specify) MARRIED	8. DATE OF BIRTH 8-9-08	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWIFE (Ret)		10B. KIND OF BUSINESS OR INDUSTRY C.&P. Tel.Col.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN CONNELLY		14. MOTHER'S MAIDEN NAME ELSIE M. Benson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
581.0 + 260X		(A) HEPATIC COMA SECONDARY TO CIRRHOSIS OF LIVER COMPLICATED BY DIABETES		HRS YRS YRS	
ANTECEDENT CAUSES		(B) MELLITUS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 27 19 65 to JULY 6 1965, that (I) (we) last saw the deceased alive on JULY 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.				23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL				23D. ADDRESS M.D. Caton & Wilkins Aves. Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 July 65		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 9 1965			
24F. NAME OF REGISTRAR Robert E. Farley, M.D.		24G. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7132				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7132	
1. NAME OF DECEASED (Type or Print) Arthur Jackson Enfield				2. DATE AND HOUR OF DEATH 7/7/65 6:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pylesville D. STREET ADDRESS (If rural, give location) Box 157					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 1/1/00	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William Enfield				14. MOTHER'S MAIDEN NAME Rachel Ann Fletcher					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES No				16. SOCIAL SECURITY NO. 212-14-2383		17. INFORMANT ADDRESS Nattie Fisher, Pylesville, Md			
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ASTHENIA				(A) DUE TO		7 mos		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		Bronchogenic carcinoma		7 mos	
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 1 19 65 to July 7 19 65 , that (I) (we) last saw the deceased alive on July 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Hudson Fesche				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/7/65			
23C. PHYSICIAN'S NAME (Type) HUDSON FESCHE				23D. ADDRESS UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-65		24C. NAME of CEMETERY or CREMATORY ST. PAUL METH. CEM.		24D. LOCATION (City, town, or county) (State) PYLESVILLE, HARFORD CO., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Fesche		25C. FUNERAL DIRECTOR Kenneth W. O'Brien		ADDRESS Stewartstown Pa.			

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 7133

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Virginia R. Griffin

2. DATE AND HOUR OF DEATH

July 8, 1965 12:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3011 Spaulding Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

6-20-11

9. AGE (In years
lost birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Sam Perticone

14. MOTHER'S MAIDEN NAME

Mary Balladarsch

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
218-12-2883

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #24

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Metastatic Carcinoma

9 Months

(B) DUE TO

Cervical Carcinoma

2 Years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Anemia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 5, 1965 to July 8, 1965,
that (I) (we) last saw the deceased alive on July 8, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

July 8, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/10/65

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 9

1965

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

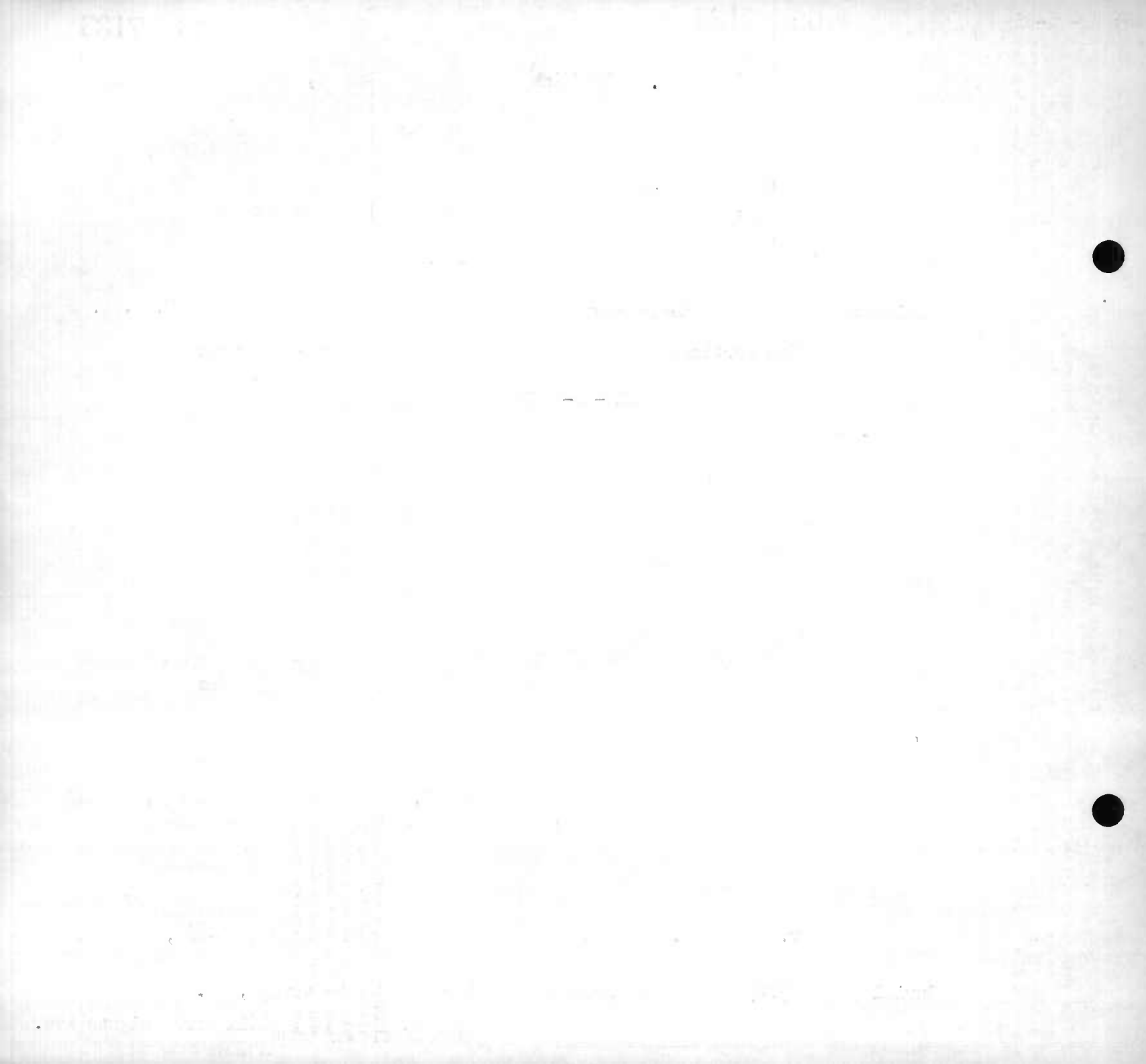
L. Vernon Lammont

ADDRESS

4611 Park Heights Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



65 7134

BALTIMORE CITY HEALTH DEPARTMENT

65 7134

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)G.
JOHN FLEMING JR.

2. DATE AND HOUR PRONOUNCED DEAD

July 3, 1965 3:30 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

101 W. 29th St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

101 W. 29th St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
divorced

8. DATE OF BIRTH

11/13/38

9. AGE (In years
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

accountant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

John G. Fleming, Sr.

14. MOTHER'S MAIDEN NAME

Ruth G. Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ruth G. Fleming Albuquerque, N.M.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of the liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Chronic ethylism
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-4-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/14/65

23C. NAME OF CEMETERY or CREMATORY

FAIRVIEW PARK CEMETERY

23D. LOCATION

(City, town, or county)

(State)

ALBUQUERQUE, NEW MEXICO

24A. DATE REC'D BY HEALTH DEPT.

JUL 9 1965

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD 4107 WILKENS AVE. 21229

1941

25

RECEIVED - DEPARTMENT OF THE ARMY

VALLEY

1941

1941

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1941

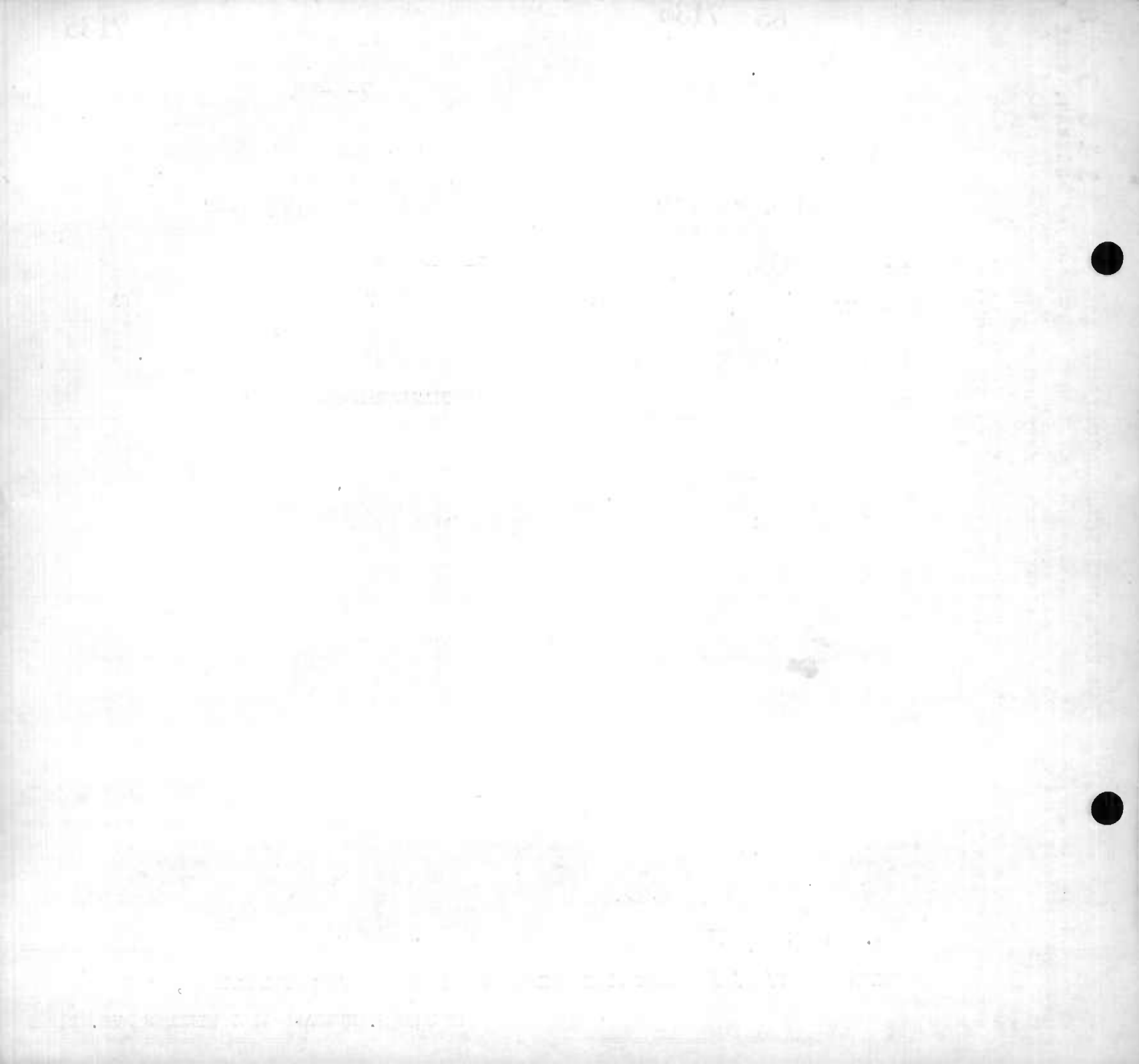
1941

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

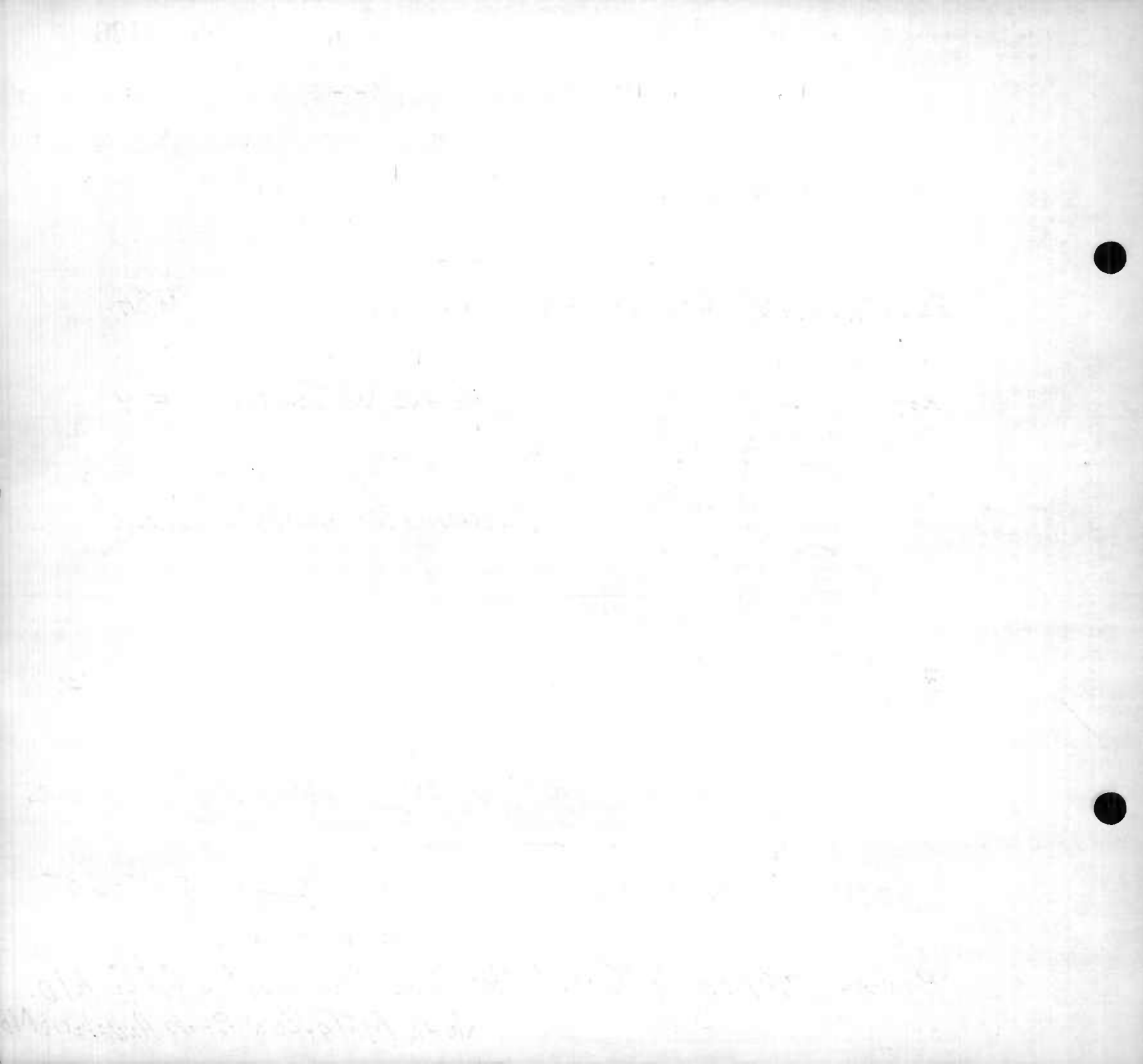
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.		CERTIFICATE OF DEATH		65 7135	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
M. ROSE CARMAN			7-6-65 10:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33. JOHNS HOPKINS HOSPITAL			A. STATE PENNA B. COUNTY V-35 C. CITY OR TOWN (If outside city limits, write RURAL and give township) EAST, PITTSBURGH D. STREET ADDRESS (If rural, give location) 781 SHADY DRIVE EAST		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 6-30-1885	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM MONTGOMERY			14. MOTHER'S MAIDEN NAME HANNAH JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.01 Pulmonary edema ANTECEDENT CAUSES Arteriosclerotic heart disease DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 hour
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 6 1965 to July 6 1965, that (I) (we) lost saw the deceased alive on July 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Cutts				23B. DATE SIGNED 7/6/65	
23C. PHYSICIAN'S NAME (Type) DR. WILLIAM CUTTS				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/65		24C. NAME of CEMETERY or CREMATORY EAST SPRINGFIELD CEMETERY	
24D. LOCATION (City, town, or county) (State) EAST SPRINGFIELD, OHIO		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7136				BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 65 7136	
M.E. CASE NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) TOMANIO, FRANK WILLIAM				2. DATE AND HOUR OF DEATH 7-5-65 5:30AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND B. COUNTY ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS D. STREET ADDRESS (If rural, give location) 27 STEELE STREET			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-13-09	9. AGE (in years lost birthday) 56	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN			10B. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH TOMANIO				14. MOTHER'S MAIDEN NAME AMELIA PAPAE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. -		17. INFORMANT PEARL W. TOMANIO		ADDRESS # 4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 410X I				CAUSE OF DEATH (A) DUE TO Mitral + Tricuspid Insufficiency (B) DUE TO Rheumatic Heart Disease (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3/6/24		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mitral Insuff.		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/22 19 65 to 7/5 19 65 , that (I) (we) last saw the deceased alive on 7/5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John R Wagner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-5-65	
23C. PHYSICIAN'S NAME (Type) JOHNS R WAGNER				23D. ADDRESS M.D. JOHNS HIPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/1965		24C. NAME of CEMETERY or CREMATORY Hillcrest Mem. Cem. Annapolis A.A.C. M.D.		24D. LOCATION (City, town, or county) (State) ANNAPOLIS M.D.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOHN M. TAYLOR		ADDRESS SONO ANNAPOLIS M.D.	



CERTIFICATE OF DEATH

Registered No. 65 7137

BIRTH NO.

65 7137

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Hattie Frank

2. DATE AND HOUR OF DEATH

July 3, 1965

1:05

P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

Maryland Edgewater

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

RURAL

D. STREET ADDRESS (If rural, give location)

Box 423

21037

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-10-1892

9. AGE (In years
last birthday)

72

If Under 1 Yr.

Months; Days

If Under 24 Hrs.

Hours; Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Clifton Sweeney

14. MOTHER'S MAIDEN NAME

Alice L. Mayhew

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

RECORDS: BCH 4940 Eastern Avenue 21224

1B.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Esophagus with
DUE TO Metastases

8 1/2 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work

Not While

At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 8, 1965 to July 3, 1965,
that (I) (we) last saw the deceased alive on July 3, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Howard Rathbun

M.D.

Attending
Phys.Med.
DirectorStaff
Phys. ☒

23B. DATE SIGNED

July 3, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-7-1965

24C. NAME OF CEMETERY or CREMATORY

Holy Cross Cem.

24D. LOCATION (City, town, or county)

Baltimore City, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 9 1965

25B. NAME OF REGISTRAR

Robert E. Finken

25C. FUNERAL DIRECTOR

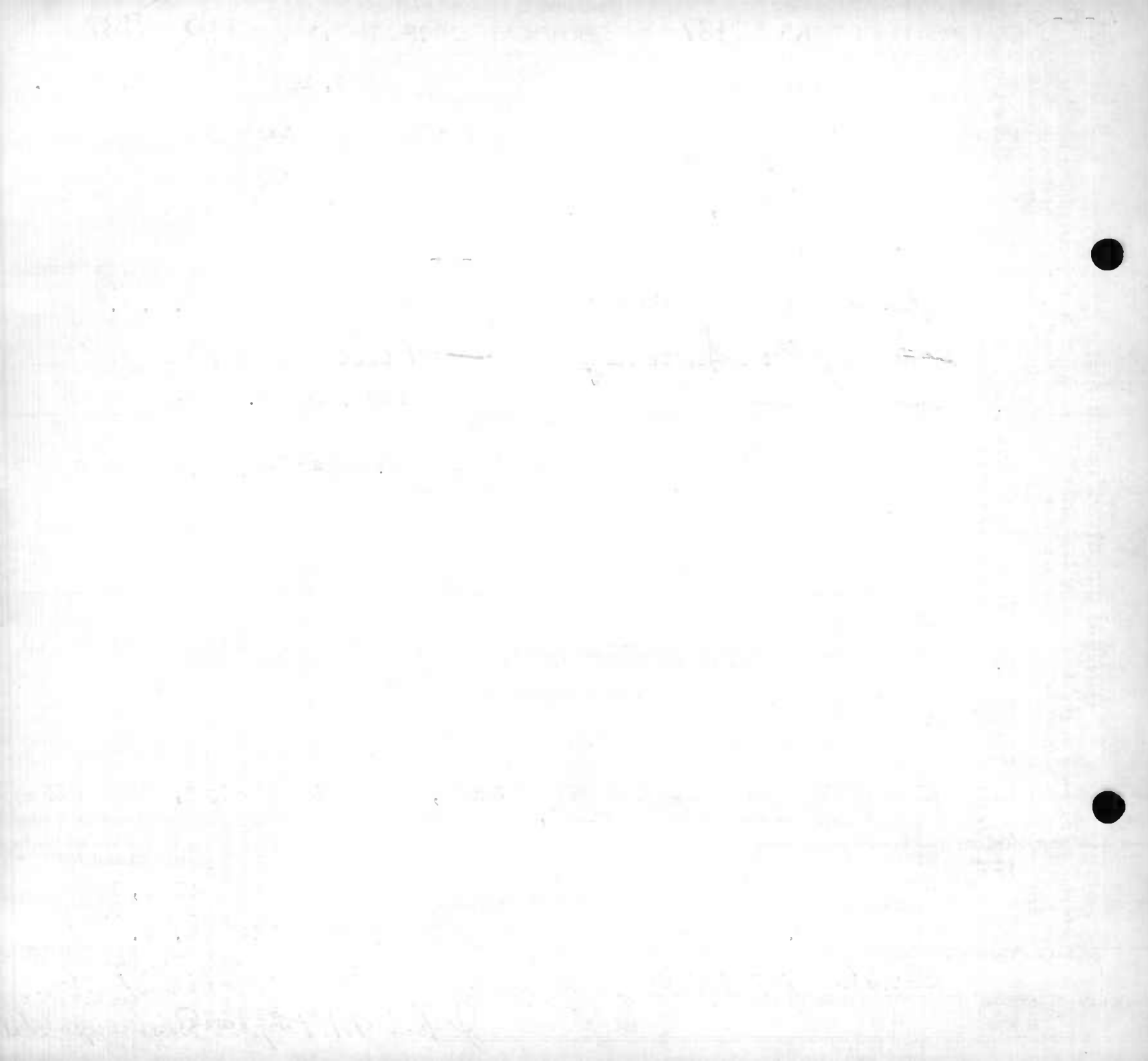
John M. Taylor

ADDRESS

Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

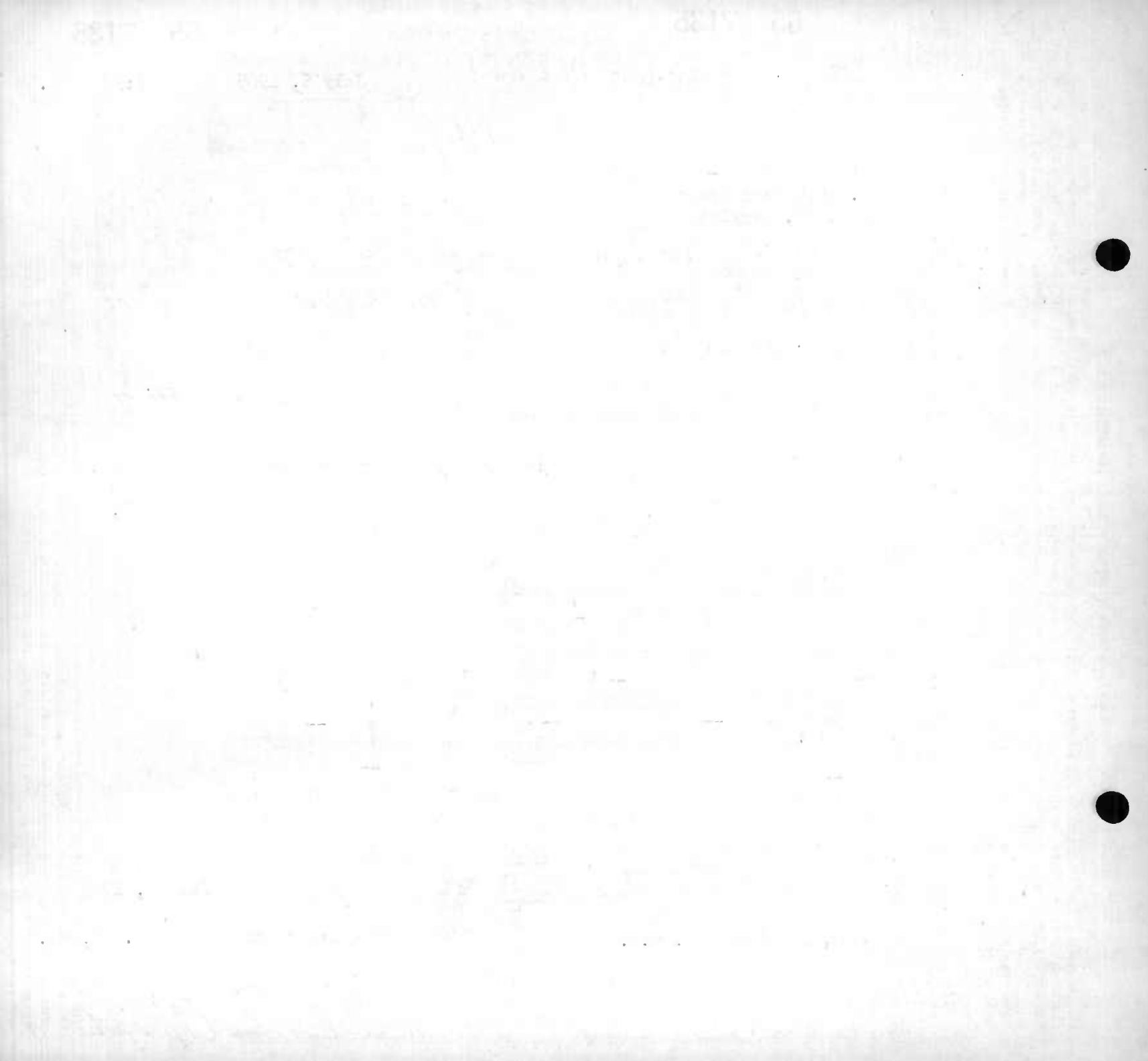
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

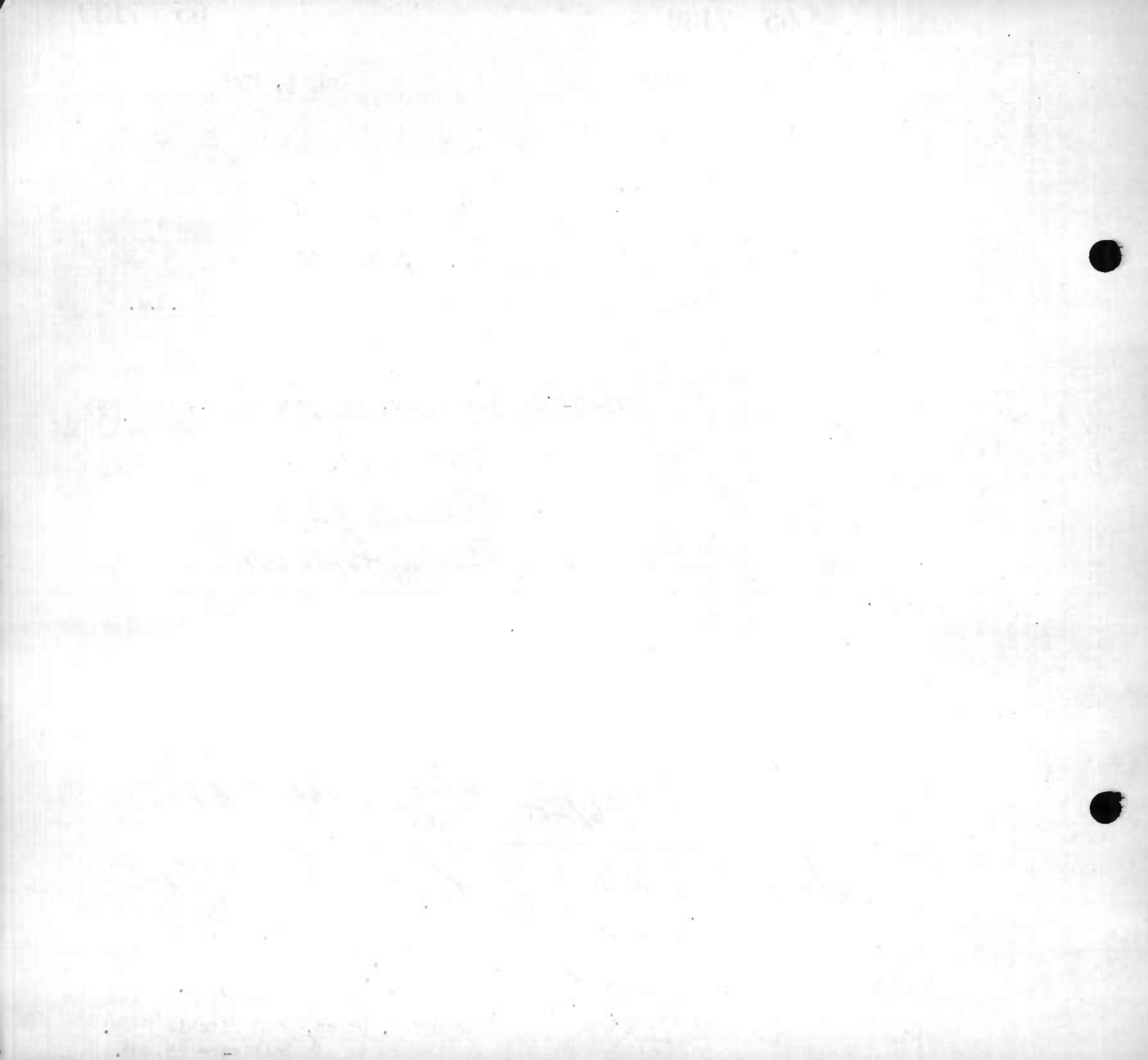
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 7138		CERTIFICATE OF DEATH		65 7138	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		Jennie Garner Michel		July 5, 1965 3:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
House in the Pines - Belvedere		Md. 16-06			
90 2525 W. Belvedere Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
Baltimore 15, Maryland		D. STREET ADDRESS (If rural, give location)		1015 Poplar Grove St.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
Female	White	Widow	12-28-1885	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Garner, Sr.		Josie Rockhold		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				William Michel #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral vascular thrombosis		March 12, 1965	
ANTECEDENT CAUSES		(B) DUE TO		to	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		July 5, 1965	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 --		--		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
--		--		--	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
--		--		--	
22. I certify that (I) (this hospital) attended the deceased from March 12 1965 to July 5 1965, that (I) (we) last saw the deceased alive on July 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Samuel Whitehouse M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				July 7, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Samuel Whitehouse, M.D.		3900 North Charles Street Balto. 18, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-8-65		Cedar Bluff	
24D. LOCATION (City, town, or county)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Annapolis Md.		John M. Taylor		Annapolis, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 9 1965		John M. Taylor		Annapolis, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

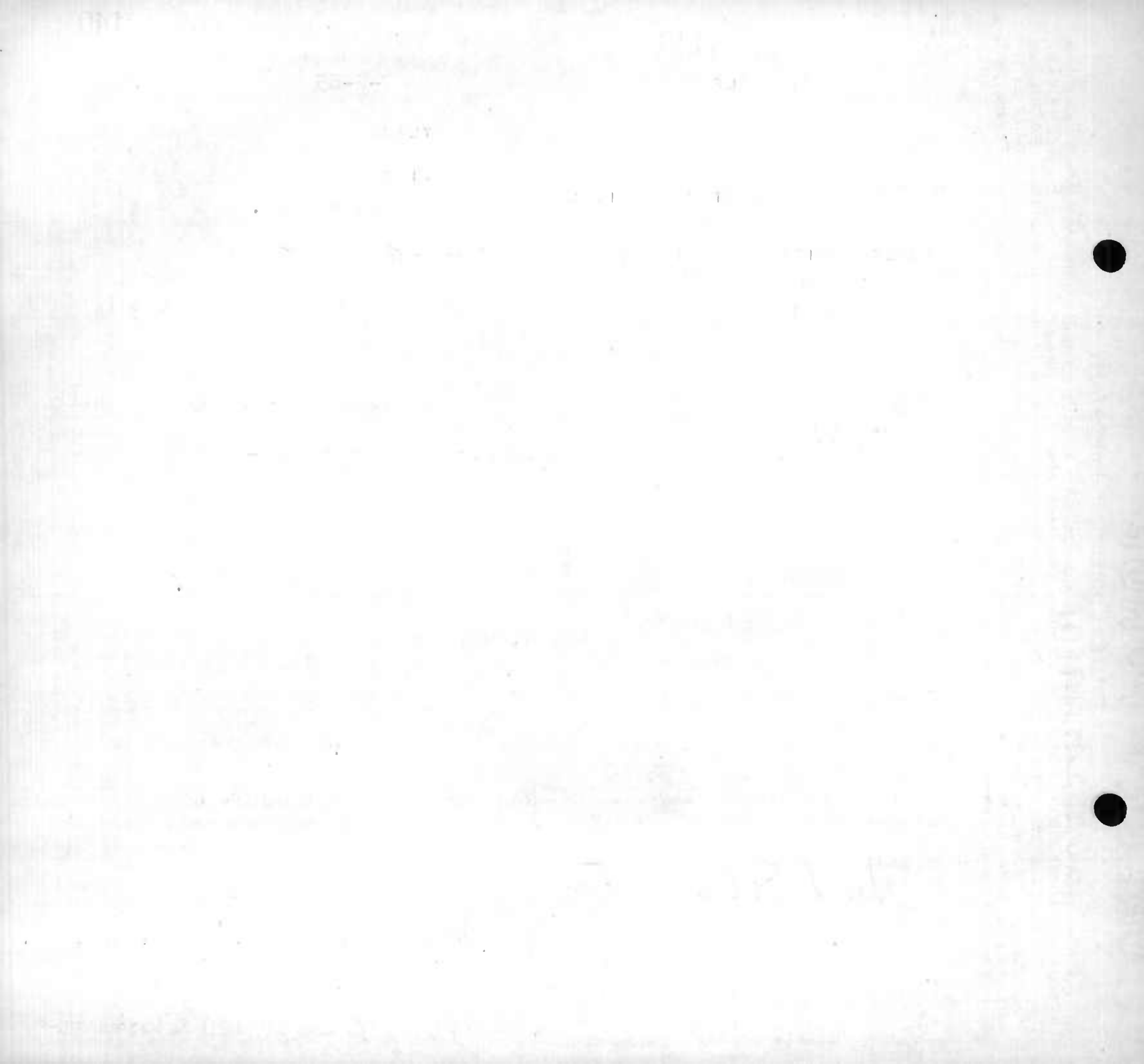
BIRTH NO. 65 7139		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7139	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ERNEST IRVIN EYLER			2. DATE AND HOUR OF DEATH July 6, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3809 HANOVER STREET			A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3809 HANOVER STREET		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN. 16, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POWDER MAKER		10B. KIND OF BUSINESS OR INDUSTRY TOOL MAKING	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME IRVIN EYLER			14. MOTHER'S MAIDEN NAME ALICE WETZEL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 173-03-2148	17. INFORMANT ADDRESS Lacy Eyler, 3809 Hanover St., Baltimore		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410x1 Metastatic Stomach Cancer			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Anemia 2nd to Bleeding Peptic Ulcer		INTERVAL BETWEEN ONSET AND DEATH Years Months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 64 to 6/25 19 65 , that (I) (we) last saw the deceased alive on 6/25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Luis Elias M.D.			23B. DATE SIGNED 7/6/65		
23C. PHYSICIAN'S NAME (Type) Luis Elias, M.D.			23D. ADDRESS 203 Patapsco Avenue Baltimore, Md. 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 8, 1965	24C. NAME OF CEMETERY or CREMATORY Greenhill Cemetery	24D. LOCATION (City, town, or county) (State) Waynesboro, Pa.		
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BIRTH NO.		65 7140	
CERTIFICATE OF DEATH				Registered No.		65 7140	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANNA WOLF				7-6-65		6:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				2722 ASHLAND AVE.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED		10-4-1969	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
95		Housewife		Maryland		USA.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Trecis				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				None		Catherine Cochran 2608 E. McElderry St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
Atherosclerotic cardio-vascular disease				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Anemia, unknown cause			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 28 1965 to July 6 1965, that (I) (we) last saw the deceased alive on July 6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Lee J. Silver							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lee J. Silver				Johns Hopkins Hosp., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-9-65		Mt. Carmel Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 9 1965		Robert E. Fickman		Phyllis E. Cochran		1211 Chesapeake Ave.	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 7141		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7141	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) LOESCH, MR. CHARLES			7/6/65 6 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Ben Secours Hospital			A. STATE MARYLAND B. COUNTY 53-00		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 1306 Glenwilde Road.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH 1/23/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - HANLINE PAINT - SHIPPER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB LOESCH		14. MOTHER'S MAIDEN NAME ANNA GOEPPERT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT MRS OTTILIE BLOECHER	
ADDRESS SAME AS #4					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 527.1 I RESPIRATORY INSUFFICIENCY			INTERVAL BETWEEN ONSET AND DEATH 2 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO SEC. TO. PULMONARY EDEMA + EMPHYSEMA		
			(C) STATUS POST-PNEUMONECTOMY, LEFT 1 month		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 4 19 65 to July 7 19 65, that (we) lost saw the deceased alive on July 7 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alexander R. Lim M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED July 7, 1965	
23C. PHYSICIAN'S NAME (Type) Alexander R. Lim M.D.				23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/65		24C. NAME OF CEMETERY or CREMATORY WESTERN	
24D. LOCATION (City, town, or county) (State) BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR John J. Harsanyi	
ADDRESS 641 Windsor Rd.					

July 7

July 7

Hosts

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. 65 7142

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) George FRANK CHANEY

2. DATE AND HOUR PRONOUNCED DEAD July 5, 1965 10:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Odenton

D. STREET ADDRESS (If rural, give location)

AA-52-00

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH Sept. 22, 1898

9. AGE (In years last birthday) 66

If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY Maintenance

11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Chaney

14. MOTHER'S MAIDEN NAME Rosie Mandilin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 212 16 5563

17. INFORMANT ADDRESS Mrs. Eva H. Chaney Wife 1131 Odenton Rd. Odenton, Md.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction

DUE TO _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Incarcerated Inguinal Hernia.

DUE TO _____

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ UNDERLYING ☐ CONTRIBUTING

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Partial

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 7/6/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE July 8, 1965

23C. NAME OF CEMETERY or CREMATORY Nichols Bethel Cemetery

23D. LOCATION (City, town, or county) (State) Odenton, Maryland

24A. DATE REC'D BY HEALTH DEPT. JUL 9 1965

24B. NAME OF REGISTRAR Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR ADDRESS HOPPING FUNERAL HOME

24D. ADDRESS ANNAPOLIS, MD.

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FUNERAL DIRECTOR: IMPORTANT

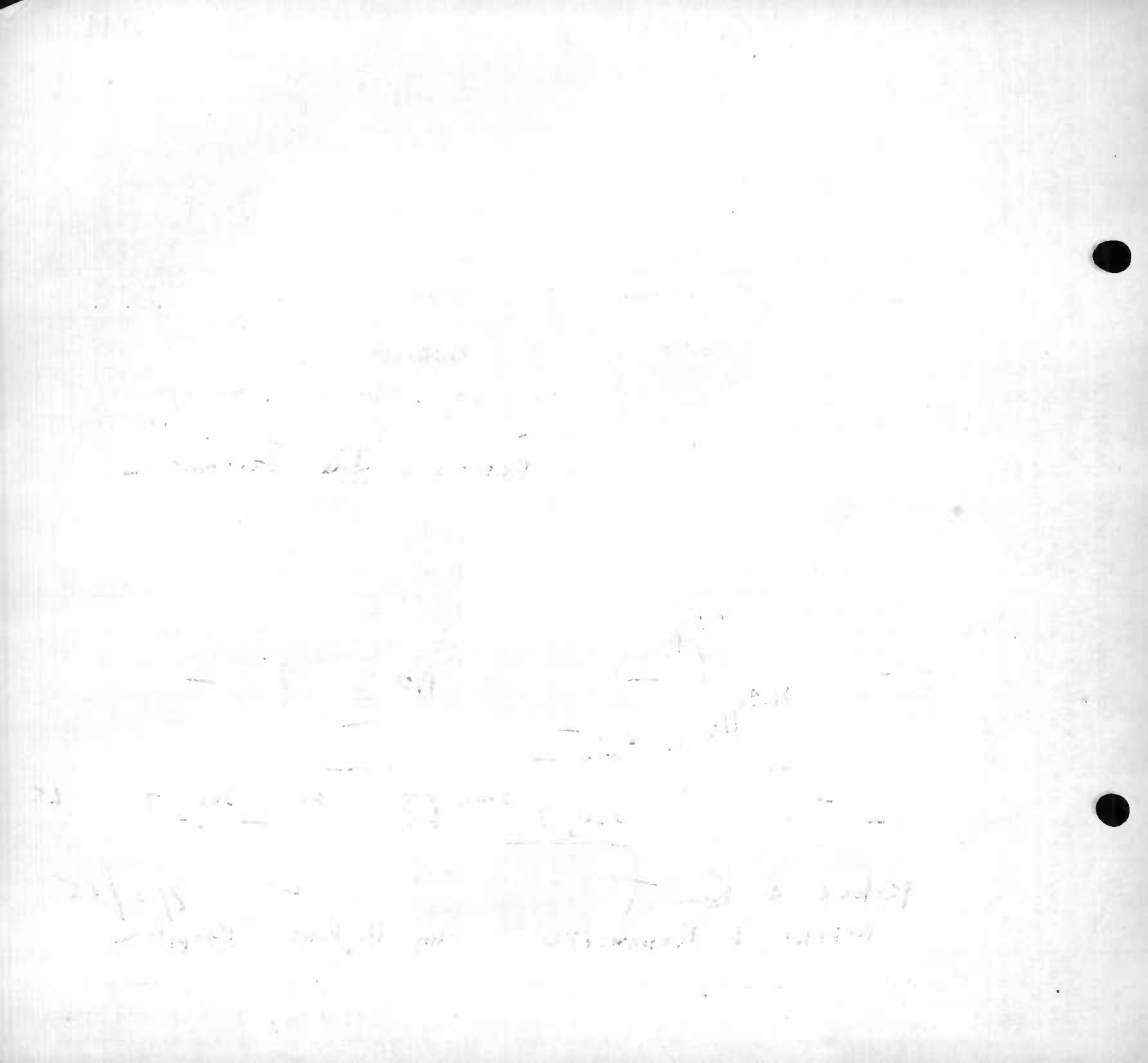
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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7143	
BIRTH NO. 65 7143		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Garten		2. DATE AND HOUR OF DEATH July 7, 1965 8:45 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in The Pines--Belvedere Baltimore, Maryland 21215		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson 53-00 D. STREET ADDRESS (If rural, give location) 905 Southerly Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 13, 1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10B. KIND OF BUSINESS OR INDUSTRY Tin Decorating Co		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Herman C. Garten		14. MOTHER'S MAIDEN NAME Marie Zalotka	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-7358A		17. INFORMANT Caroline N. Garten (Wife) 905 Southerly Rd. Towson, Md. 21204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 337X I Cerebral Hemorrhage Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 hrs		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 60 to July 7 1965, that (I) (we) last saw the deceased alive on July 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (did not) view the body after death.					
23A. SIGNATURE Laurence C. Post		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type) Laurence C. Post		23D. ADDRESS 6805 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/1965		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965			
25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Baltimore, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7144	
BIRTH NO. 65 7144		M.E. CASE NO. W.		1. NAME OF DECEASED (Type or Print) CATHERINE BROWN	
2. DATE AND HOUR OF DEATH 7-7-65 11.59 P M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. SEX FEMALE			
A. STATE MARYLAND		6. RACE WHITE			
B. COUNTY 26-09		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		8. DATE OF BIRTH 9-29-94			
D. STREET ADDRESS (If rural, give location) 719 SOUTH FAGLEY STREET		9. AGE (In years last birthday) 70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ? Wujtowicz		14. MOTHER'S MAIDEN NAME VICTORIA WUGMC	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Adam F. Brown 719 S. Fagley Street	
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Reticulum Cell Sarcoma		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? -		22. I certify that (H) (this hospital) attended the deceased from June 25 1965 to July 7 1965, that (I) (we) last saw the deceased alive on July 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert I. Keimowitz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/8/65	
23C. PHYSICIAN'S NAME (Type) ROBERT I. KEIMOWITZ		M.D. 23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-1965		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart	
24D. LOCATION Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Feltner	
25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 7145		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7145	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Adore Kraft</i>			
2. DATE AND HOUR OF DEATH <i>9:00 AM 6/24/65</i>				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY <i>27-19</i>	
5. SEX <i>MALE</i>				6. RACE <i>WHITE</i>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>				8. DATE OF BIRTH <i>3-29-1898</i>			
9. AGE (In years lost birthday) <i>67</i>				10. AGE (In years lost birthday) <i>67</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CUTTER</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>CLOTHING</i>			
11. BIRTHPLACE (State or foreign country) <i>POLAND</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>ABR9H9M</i>				14. MOTHER'S MAIDEN NAME <i>S9R9H</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-07-6231</i>			
17. INFORMANT <i>BENTRICE KRAFT</i>				ADDRESS <i>SAME</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary artery disease.</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>6/24/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/24/65</i> 19 to <i>6/24</i> 1965, that (I) (we) last saw the deceased alive on <i>never</i> 19 and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M.F. SAIONT2</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/24/1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>M.F. SAIONT2</i>				23D. ADDRESS <i>Sinai Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/27/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>HERRING TRUN</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>SYLVAN F. LEWIS & SON, INC. - 3319 OLYMPIA AVE</i>			

1915

31st Dec

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W.F. CHILDS
1915

1
P-100

65 7146

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 7146

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LUTHER R. POPE

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1965 9:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 16-03
2746 Winchester Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 28, 1902

9. AGE (In years lost birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Arthur Pope

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.
217-03-8433

17. INFORMANT ADDRESS
Sarah Pope 2746 Winchester St.

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7/10/65

23C. NAME of CEMETERY or CREMATORY

Church Cem.

23D. LOCATION (City, town, or county)

Lancaster Co. Va.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

George A. Kohn 1348 N. Calhoun St.

ADDRESS

RECEIVED CO. 100-100000

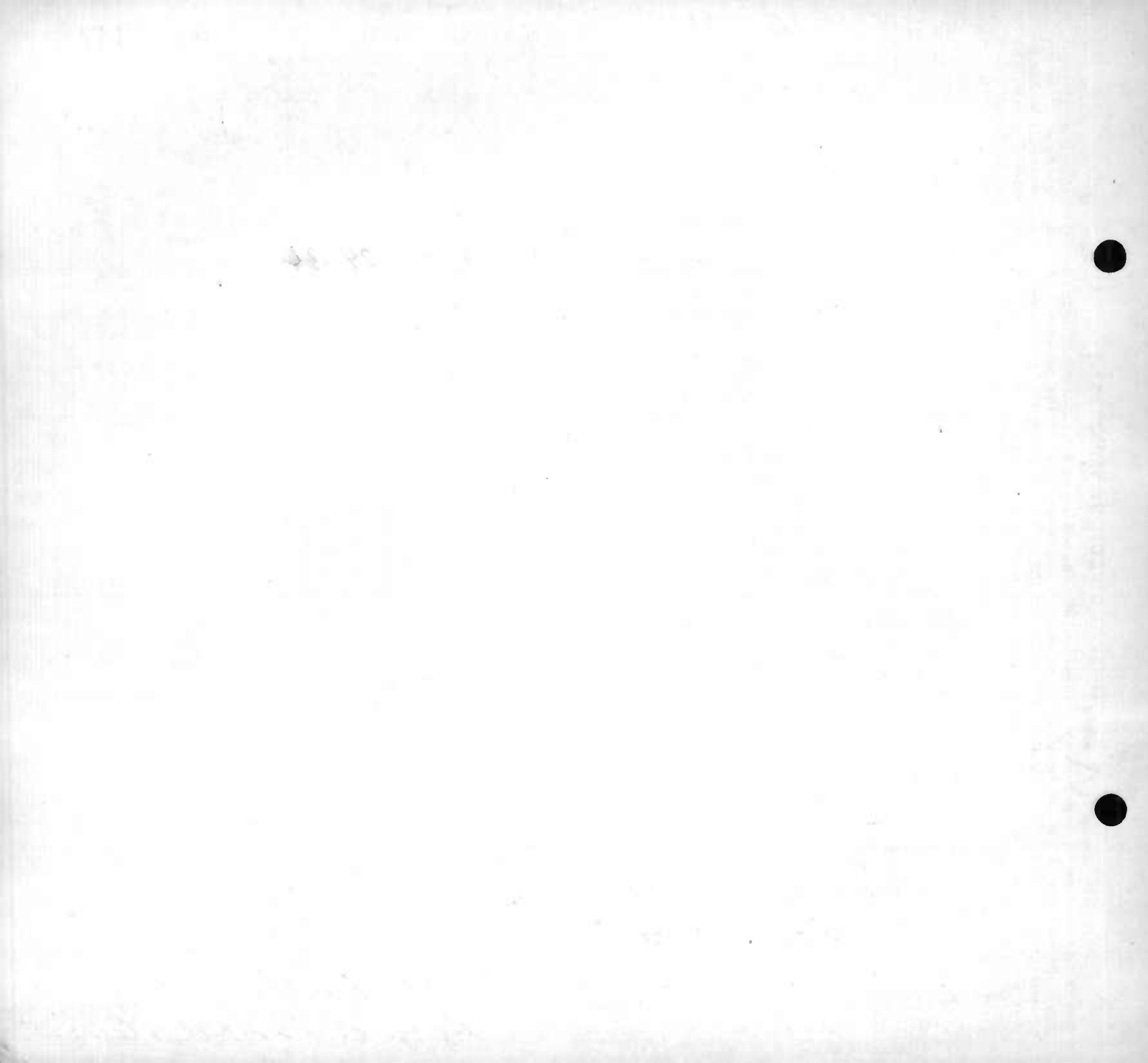
100-100000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7147				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7147	
1. NAME OF DECEASED (Type or Print) <u>Alvin Bayton</u>				2. DATE AND HOUR OF DEATH <u>7/5/65</u> <u>12 50</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY OF MARYLAND HOSPITAL</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>16-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1125 FULTON AVENUE #17</u>					
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>11/18/1934</u>		9. AGE (In years last birthday) <u>30</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>CARTON DAYTON</u>			14. MOTHER'S MAIDEN NAME <u>ANNA BE LL OWENS</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MOTHER</u> ADDRESS <u>1125 FULTON AVENUE</u>				
18. <u>445X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>Arteriosclerotic Nephrosclerosis</u> DUE TO (C) <u>Malignant Hypertension, Essential</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>3 mos</u> <u>3 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2 None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>44</u> (this hospital) attended the deceased from <u>6-19</u> 19 <u>65</u> to <u>7-5</u> 19 <u>65</u> , that (I) <u>we</u> last saw the deceased alive on <u>7-4-65</u> 19 <u>65</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.									
23A. SIGNATURE <u>Henry A. Saiontz</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <u>7-5-65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Henry A. Saiontz</u>		23D. ADDRESS M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-9-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. PK</u>		24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>George A. Kiber</u>		ADDRESS <u>1348 N. Calhoun St</u>			



BIRTH NO. 65-16125 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAQUELINE

PARKER

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1965

5:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2141 W. Baltimore Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

June 21, 1965

9. AGE (In years
last birthday)10 Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

18

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Parker

14. MOTHER'S MAIDEN NAME

Bertha

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Wm. Parker 2141 W. B. H. St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-10-65

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pl.

23D. LOCATION (City, town, or county)

Arbutus, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 9

1965

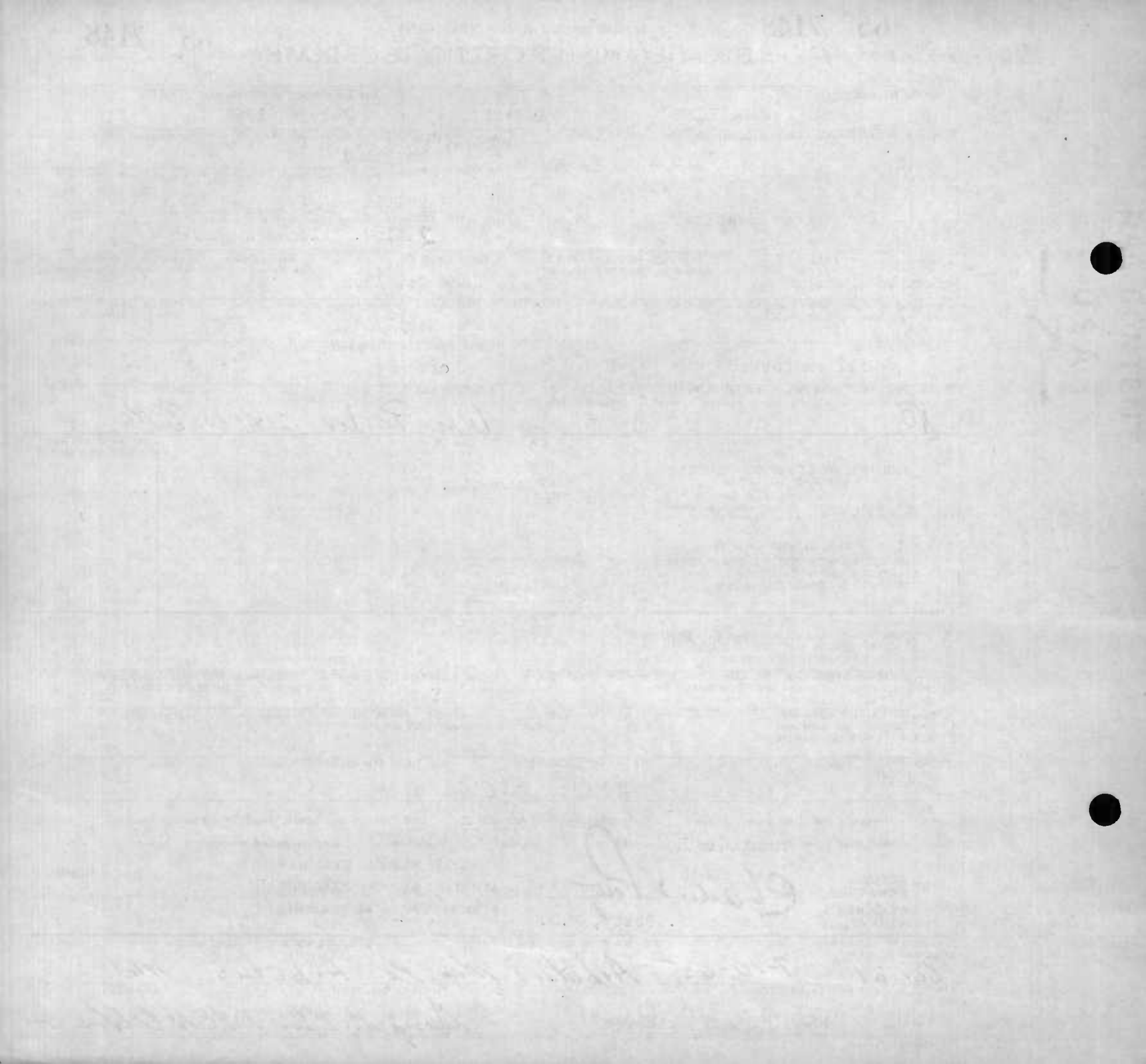
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

George A. Kibbe 1548 N. Calton St

ADDRESS

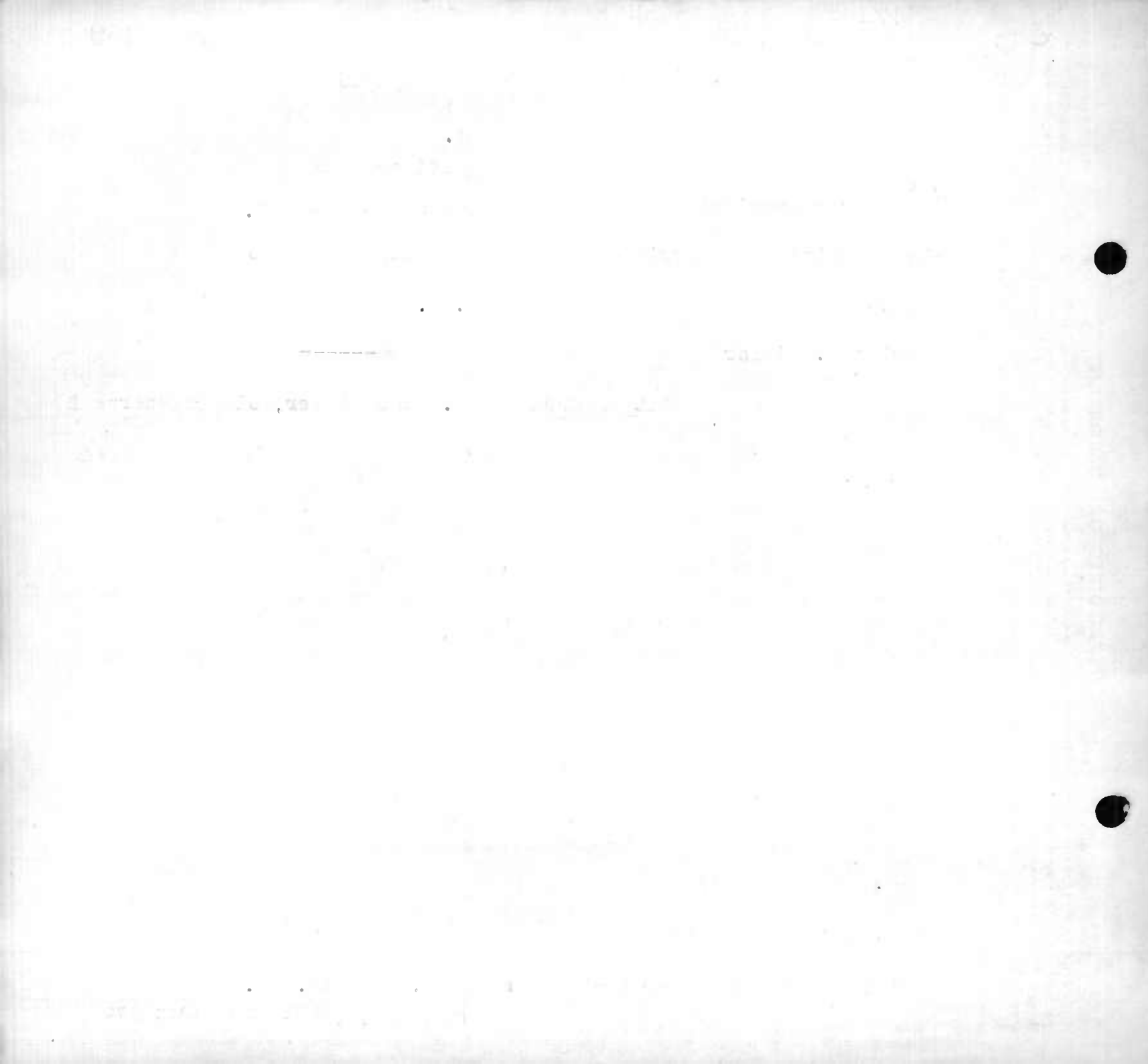


BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
65 7149						65 7149	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
SAMUEL MARTIN (Charles)				7/6/65 11:59 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland B. COUNTY			
46 Lutheran Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-04 D. STREET ADDRESS (If rural, give location) 2112 N. Fulton Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
male	colored	Widowed	Jan. 26, 1910	55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					N.C.		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Pleas Martin				Carrie Black			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No			212-16-9776		Cora Rice 2112 N. Fulton Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
				Carcinomatosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				no			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
Rudiger Breitenecker, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/7/65	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		7/10/65		Arbutus Mem. Pk.		Arbutus, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
JUL 9 1965		Robert E. Farley, M.D.		George A. Kilar		1348 N. Calhoun St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

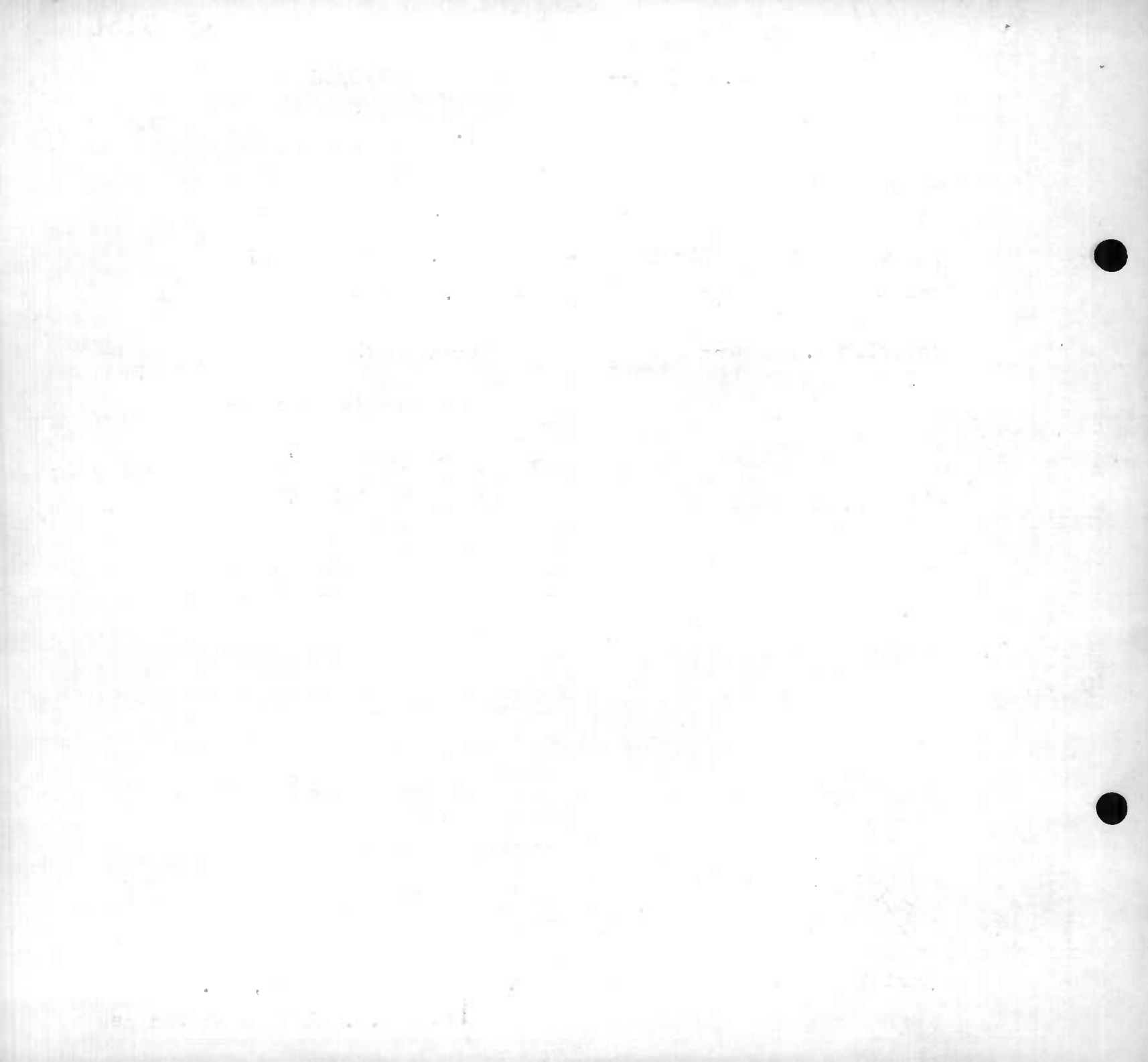
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7150	
BIRTH NO. 65 7150		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles W. Miller		2. DATE AND HOUR OF DEATH 7/6/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		Md. 28-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29	
		D. STREET ADDRESS (If rural, give location) 4618 Coleherne Rd.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 16/02	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles A. Miller		14. MOTHER'S MAIDEN NAME Florence-----		17. INFORMANT Mrs. Rose Miller, 4618 Coleherne Rd.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 03 0982		ADDRESS Zone 79	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) acute coronary thrombosis		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3-5-65	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2-65 11-17-65 19 to 7-6-65 19 that (I) (we) last saw the deceased alive on 7-2-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry S. Gimdel		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-8-65	
23C. PHYSICIAN'S NAME (Type) HARRY S. GIMDEL		M.D. 23D. ADDRESS 4605 Edmondson Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Pk.	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

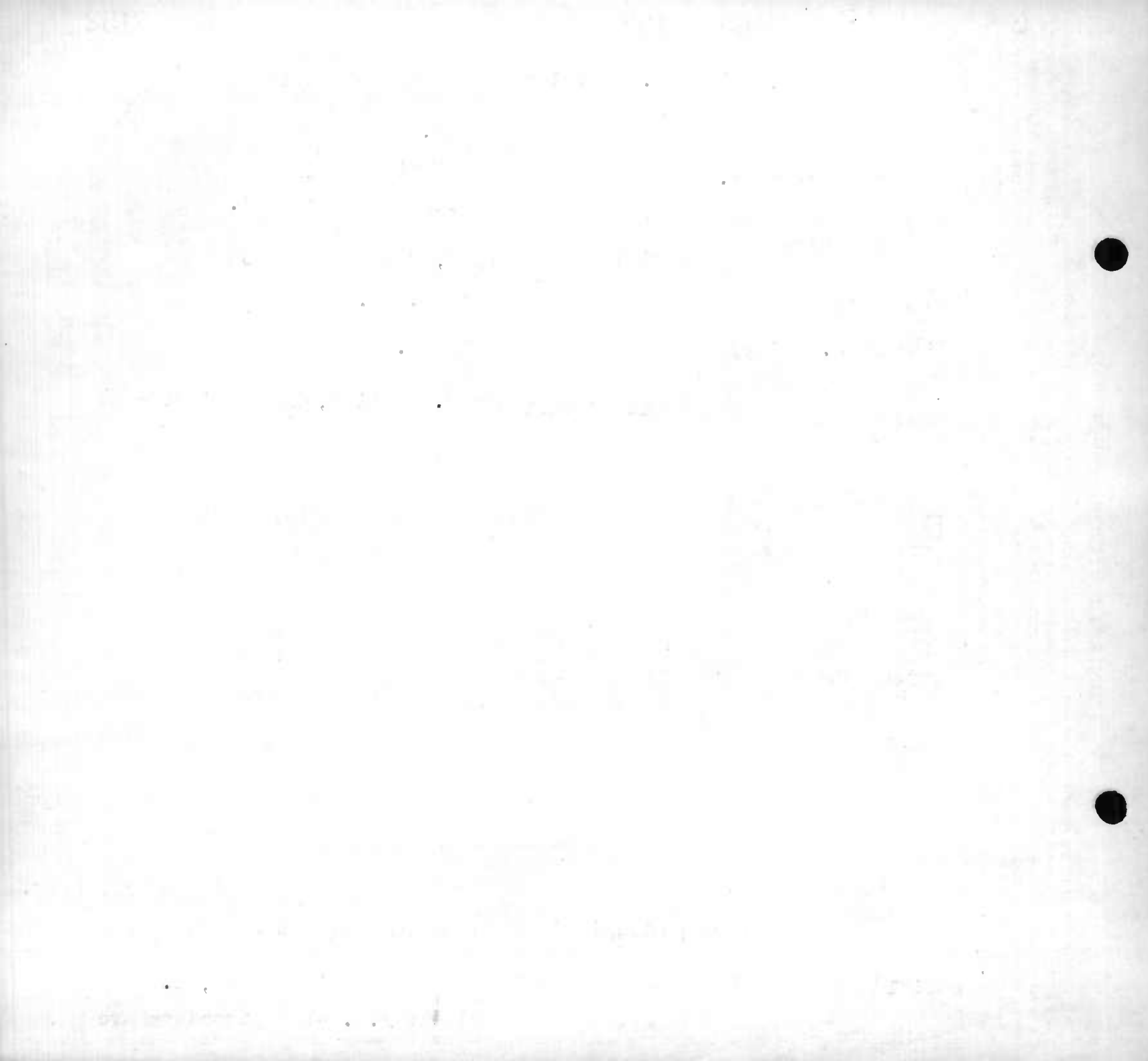
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 7151	
BIRTH NO. 65 7151		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary M. Goldmann		2. DATE AND HOUR OF DEATH 7/6/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 20-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2523 McHenry St			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Oct. 2/88	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick A. Goldmann				14. MOTHER'S MAIDEN NAME Anna Vaeth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Miss Rosalie Goldmann			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Arteriosclerotic Hyper-tensive cardio-vascular disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/9 to 7.6 , 19 65 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Justin J. Kupirka M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 7.8.65			
23C. PHYSICIAN'S NAME (Type) Justin J. Kupirka M.D.				23D. ADDRESS 2151 McHenry Ave			
24A. BURIAL-CREATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR ADDRESS Witzke F.D. 4101 Edmondson Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 7152	
BIRTH NO. 5		65 7152					
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Catherine E. Gallion		July 6/65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
613 Woodington Rd.				Md.		16-08	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 29			
				D. STREET ADDRESS (If rural, give location)			
				613 Woodington Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
Female	White	Married	7/25, 1904	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Saleslady			Balto. Md.		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Gilbert J. Dailey			Mary L. McGroden				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
			216 30 7591		Leo F. Gallion, 613 Woodington Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO			6 mo.	
ANTECEDENT CAUSES			(B) DUE TO			1 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)				
II			Pneumonia - lobar - (C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
JAN. 1965		Ca-parotid		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Jan. 19 65 to July 6 19 65, that (I) (we) last saw the deceased alive on Jan. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
C.G. Baumann						7-6-1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
C.G. BAUMANN				LINTHICUM HEIGHTS, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/9/65		New Cathedral		Baltimore 29, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 9 1965		R.C. & S. F. D.		Witzke F.D.		4101 Edmondson Ave	



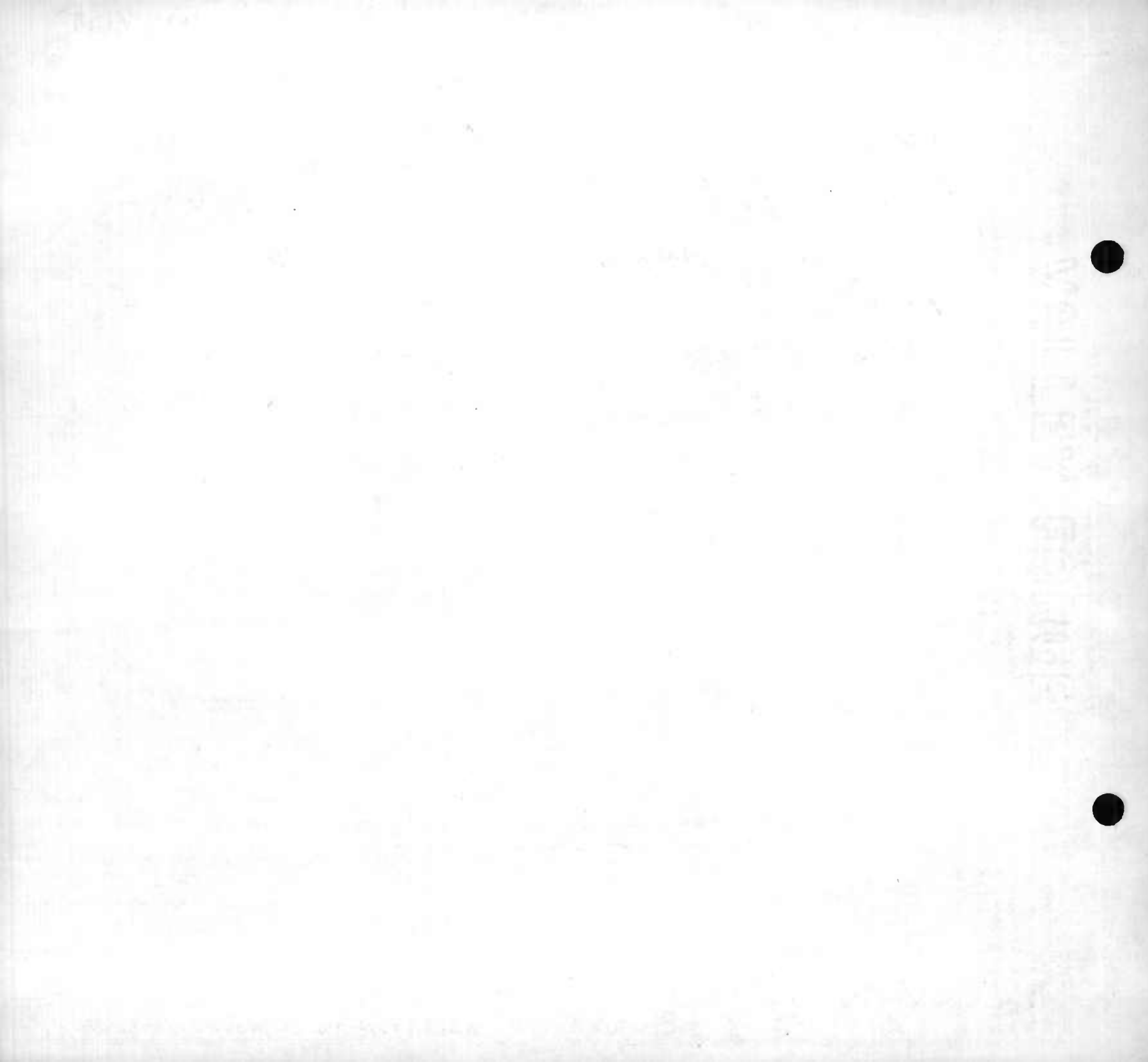
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1-257 65 7153				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7153	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Charles Hickenbottom				2. DATE AND HOUR OF DEATH July 4, 1965 6:AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Annapolis C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL 52-10 D. STREET ADDRESS (If rural, give location) 59 N. Washington Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 10-20-93	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Adenocarcinoma of the Colon 1 1/2 Years II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 4, 1965 to July 4, 1965, that (I) (we) last saw the deceased alive on July 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald Baltzan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Donald Baltzan				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Ann Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Wm. C. March		ADDRESS 428 E. North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7154	
BIRTH NO. 65 7154		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES BIONDO (BIONDIO)		2. DATE AND HOUR OF DEATH 7-7-1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL DOA		A. STATE MARYLAND B. COUNTY 17-01			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 518 W. MULBERRY ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-13-1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRODUCE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
13. FATHER'S NAME JAMES BIONDO		14. MOTHER'S MAIDEN NAME JOSEPHINE CARNAGGIO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ROSALIA BIONDO 518 W. MULBERRY ST	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Hepatic failure -			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/5 to 7/7 1965, that (I) (we) last saw the deceased alive on 6/7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Joseph R. Liberto		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO		23D. ADDRESS 3508 Bank St -			
24A. BURIAL CREMATION, REMOVAL BURIAL		24B. DATE 7/10/1965		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL	
				24D. LOCATION BALTIMORE (City, town, or county) (State) MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR ADDRESS WEBER FUNERAL HOME 5311 EDMONDSON AVE	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL ROBERT HARRINGTON

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1965

10:30 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2043 Gough St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2043 Gough St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-27-1923

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Calvin Harrington

14. MOTHER'S MAIDEN NAME

Anna Miliancz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

220053200

17. INFORMANT

ADDRESS

Dorothy Harrington 2043 Gough St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of the liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute ethylism

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
7-7-6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-10-1965

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John M. Weber & Sons, Inc.
401 S. Chester St.

ADDRESS

VALLEY FORD

HAS CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7156				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7156	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Faulkner, Mrs. Mary E.</i>		2. DATE AND HOUR OF DEATH <i>July 8, 1965 12:00 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home & Hospital</i>				A. STATE <i>Maryland</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)				B. COUNTY		D. STREET ADDRESS (If rural, give location) <i>161 Bennett Rd</i>			
5. SEX <i>F</i>		6. RACE <i>Cau</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>May 30, 1898</i>		9. AGE (In years last birthday) <i>67</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Textile Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Busby</i>				14. MOTHER'S MAIDEN NAME <i>Mollie</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>237-03-4772</i>				17. INFORMANT <i>Mrs. Earl Catterton</i>		ADDRESS <i>161 Bennett Road Baltimore, Md. 21</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>PARTIAL INTESTINAL OBSTRUCTION DUE TO INTESTINAL ADHESION</i>				CAUSE OF DEATH (A) <i>obstruction due to</i> DUE TO <i>INTESTINAL ADHESION</i>		INTERVAL BETWEEN ONSET AND DEATH <i>days</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>GENERALIZED ARTERIOSCLEROSIS</i>				(B) <i>GENERALIZED</i> DUE TO <i>ARTERIOSCLEROSIS</i>		(C) <i>ATROPHIC LEFT KIDNEY</i> <i>YEARS</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>RESECTION of GASTRIC CARCINOMA 15 YEARS AGO</i>									
19A. DATE OF OPERATION <i>7-7-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At <input type="checkbox"/> Home		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>7-7-65</i> to <i>7-8-65</i> that (I) (we) last saw the deceased alive on <i>7-8-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Ephraim B. Barzaga</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/8/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Ephraim B. BARZAGA</i>				23D. ADDRESS <i>CHURCH HOME & Hospital-BALTO 31 MD</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>7/8/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sunset Memorial</i>		24D. LOCATION (City, town, or county) (State) <i>Henderson, N. Carolina</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Faulkner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Balto. Md. 21217 Wm. J. Feinberg, 1000 North & Pa. Ave.</i>					

Partial intestinal
obstruction due to
intestinal adhesions
Generalized
water retention
Atrophic left kidney

Retention of gastric
contents
V.C.

7-8-72

Pharmaceutical
Pharmaceutical

Pharmaceutical

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

HONEY VICTORIA

BELL

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1965

8:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

650 Portland Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11/27/96

9. AGE (in years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander Harris

14. MOTHER'S MAIDEN NAME

Ann Boulden

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Albe rta Day 650 Portland St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Massive Subarachnoid and Intracerebral

~~Stroke~~ Hemorrhage

due to

(B) Rupture of Aneurysm of Basilar Artery.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/12/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 9 1965

Robert E. Fabela

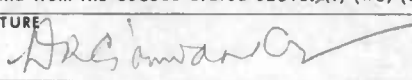
Charles A. Rice 661 W. Barre St.

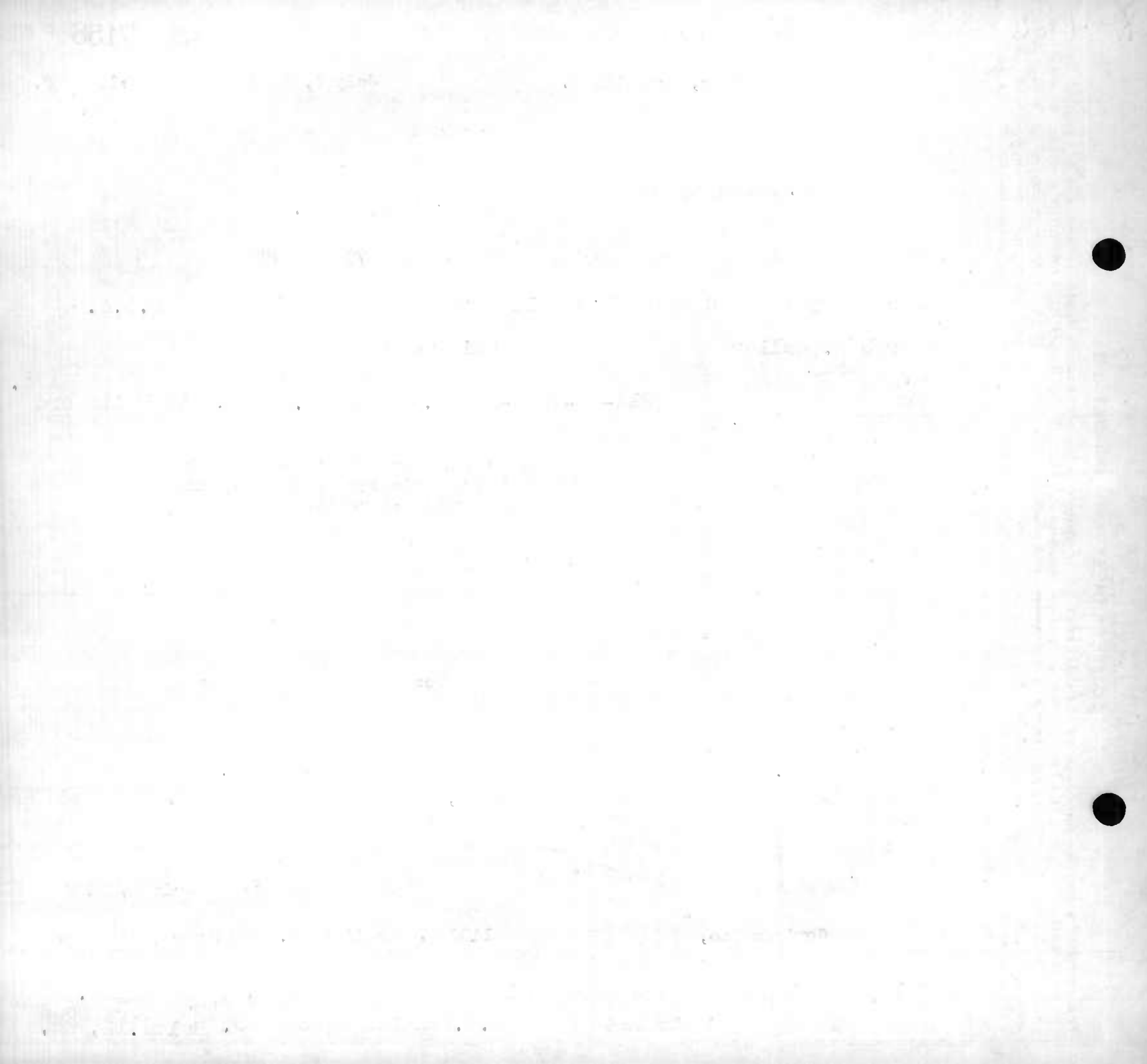
WALLINGTON OFFICE

Class 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

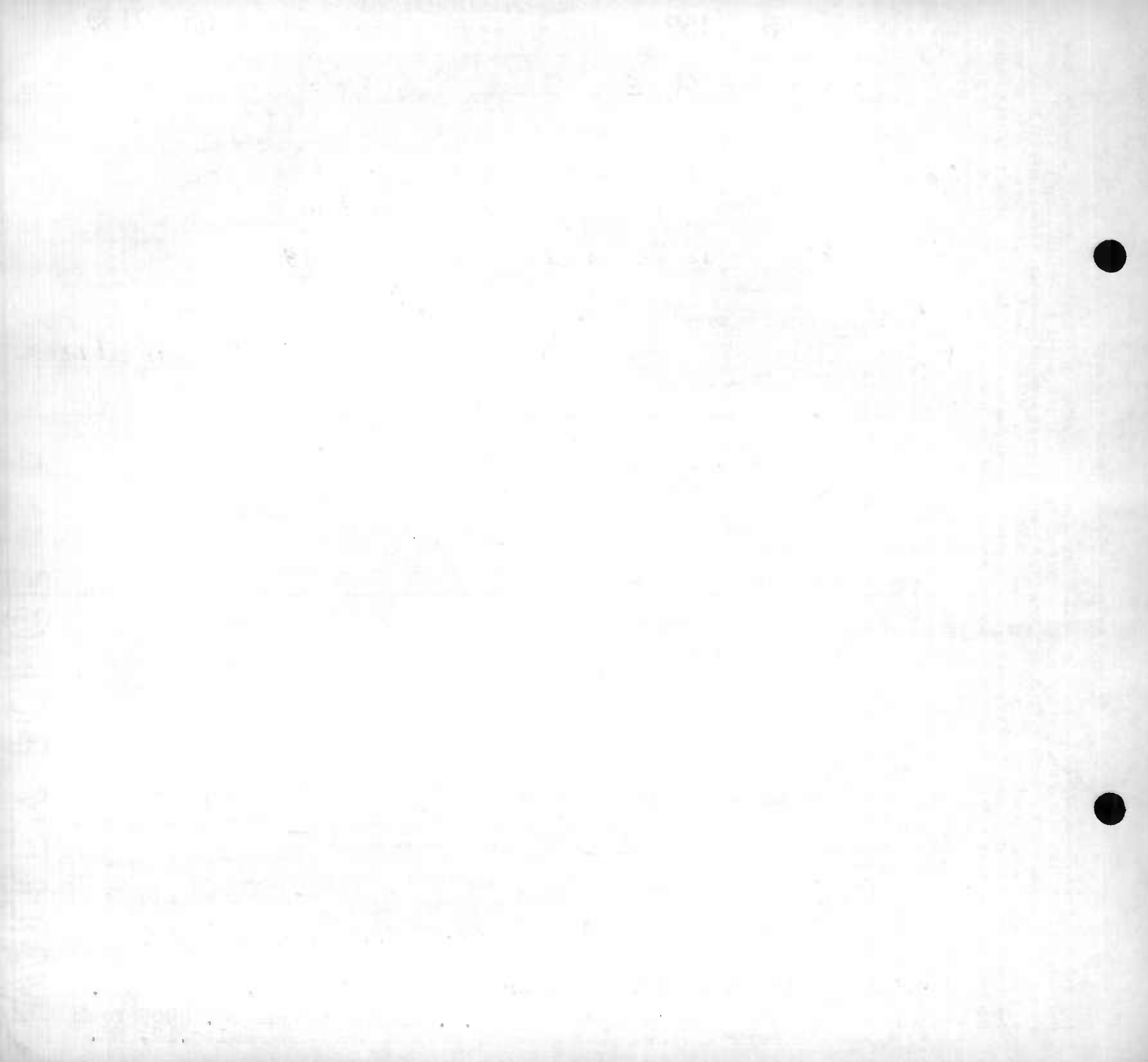
BIRTH NO. 65 7158		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7158	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Keller, Isabella M.		July 7, 1965 9:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		27-11	
FULL NAME OF HOSPITAL OR INSTITUTION 41 St. Joseph Hospital		A. STATE Maryland		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21212		D. STREET ADDRESS (If rural, give location) 5118 Whiteford Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH Sept. 30, 1879	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Crosse & Blackwell		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George A. Keller		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-7299-A		17. INFORMANT Mrs. Loretta K. McGee, 5118 Whiteford Ave.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Generalized arteriosclerosis with acute left ventricular hypertrophy and myocardial fibrosis. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from June 23, 19 65 to July 7, 19 65, that (H) (we) last saw the deceased alive on July 7, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Govinda Rao,				23B. DATE SIGNED July 8, 1965	
M.D. Attending Phys. <input type="checkbox"/>		Med. Director <input type="checkbox"/>		Staff Phys. <input checked="" type="checkbox"/>	
23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/1965		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Md.		24E. ADDRESS 4905 York Road, Balto. 12, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7159	
BIRTH NO. 65 7159		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PARR EVA E.		2. DATE AND HOUR OF DEATH July 8, 1965 13⁴⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital 49		A. STATE Maryland B. COUNTY 12-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 302 Southway			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 8-14-1881	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PARR Joseph		14. MOTHER'S MAIDEN NAME Catherine EBERENZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Chart	
18. 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Arteriosclerotic Cardiovascular disease, renal failure DUE TO (B) with uremia DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 5, 1965 to July 8, 1965 , that (I) (we) lost saw the deceased alive on July 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George Kibuka		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 8, 1965	
23C. PHYSICIAN'S NAME (Type) Joseph Blum		23D. ADDRESS 1115 N. Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/1965		24C. NAME of CEMETERY or CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) Baltimore,		(State) Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965	
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOHN

A.

BOWERS

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1965

6:00 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

41 St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2114 N. Calvert Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Dec 15, 1932

9. AGE (In years
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John D. Bowers

14. MOTHER'S MAIDEN NAME

Mattie Laura Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

213-30-4637

17. INFORMANT

Mattie Laura Bowers Forbes 1020 J.

ADDRESS

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab Wound of Chest.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

7

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2114 Calvert Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 7 '65 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Stabbed during altercation.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 12/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl Cem.

23D. LOCATION

(City, town, or county)

(State)

5501 Fredrick Ave.

24A. DATE REC'D BY HEALTH DEPT.

JUL 9 1965

24B. NAME OF REGISTRAR

Charles E. Forbes M.D.

24C. FUNERAL DIRECTOR

Joseph T. Chickow 1129 N. Caroline St.

ADDRESS

1880

1880

WALBURY FOUNDRY

WALBURY FOUNDRY

Charles J. Walbury

BALTIMORE CITY HEALTH DEPARTMENT

65 7161

BIRTH NO. 65 7161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) GRACE *Marie* HALL

2. DATE AND HOUR PRONOUNCED DEAD July 5, 1965 8:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
33 Johns Hopkins Hospital

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

7. STREET ADDRESS (If rural, give location)
1027 McDonough Street

8. SEX Female 9. RACE Negro 10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single

11. DATE OF BIRTH 3-7-1929 12. AGE (In years last birthday) 36

13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canner 14. KIND OF BUSINESS OR INDUSTRY Factory

15. BIRTHPLACE (State or foreign country) Baltimore, Md. 16. CITIZEN OF WHAT COUNTRY? U.S.A.

17. FATHER'S NAME Bernard Hall 18. MOTHER'S MAIDEN NAME Susie Brown

19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 20. SOCIAL SECURITY NO. 214-24-7166

21. INFORMANT Mrs. Susie Hall 1027 McDonough St.

22. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

(A) Fatty Liver and Cirrhosis. DUE TO

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Charles S. Petty* M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER ☒

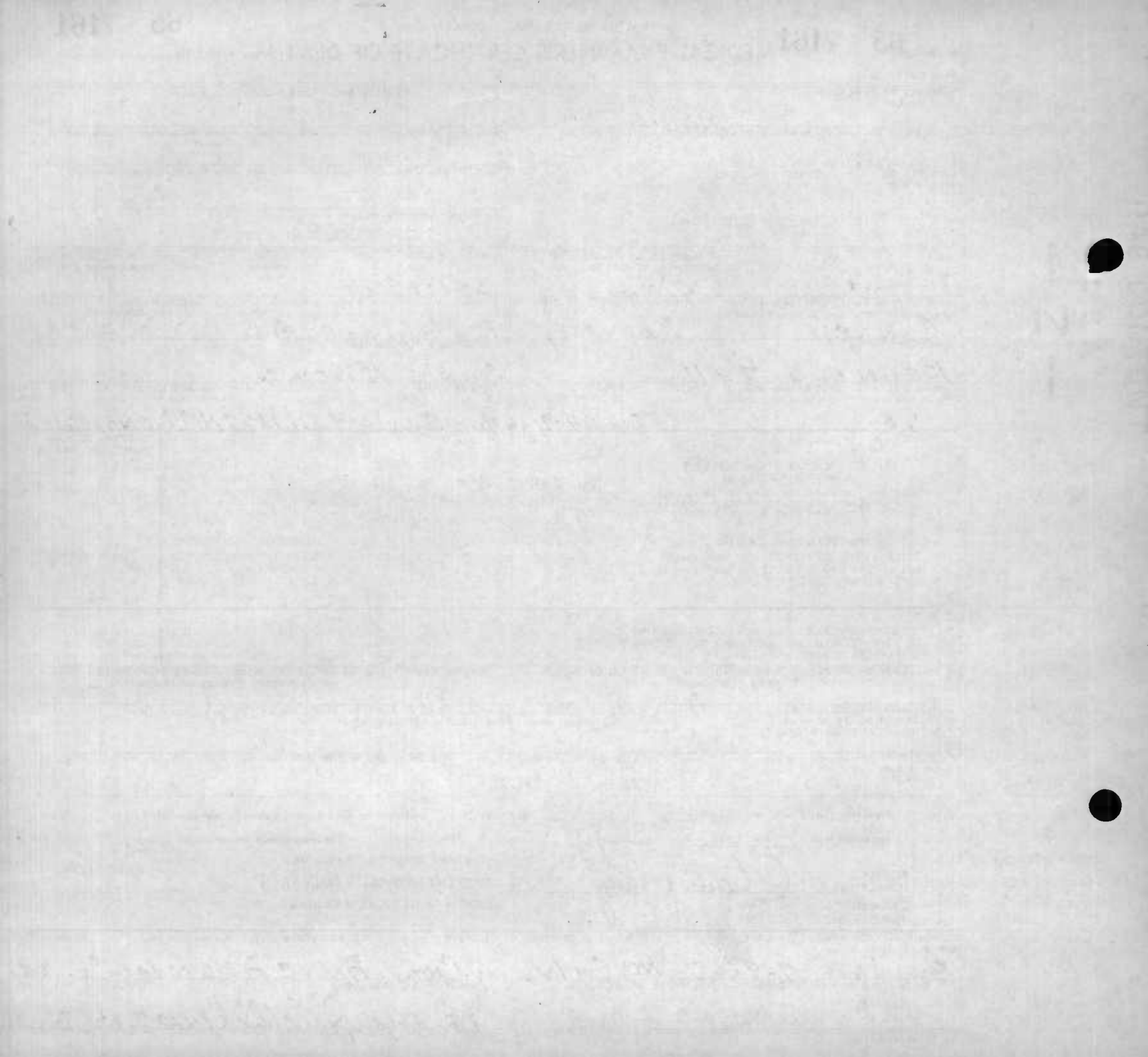
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 7/6/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 7-9-65 23C. NAME OF CEMETERY or CREMATORY McCalvary Ctry. Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT. JUL 9 1965 24B. NAME OF REGISTRAR Robert E. Fadden, M.D. 24C. FUNERAL DIRECTOR Randolph J. Collick 1412 E. Preston St.

24D. ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7162				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7162	
M.E. CASE NO.				1. NAME OF DECEASED			
Amelia J. Wilson				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Anderson Nursing Home				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3603 Sylvan Drive			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Married		Dec. 3, 1875	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
At Home				89		Baltimore, Md.	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Charles Reuer				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				None			
17. INFORMANT				ADDRESS			
Carl J. Wilson				215 Adams Street			
				Brooklyn 1, New York			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 3rd 1965 to July 7th 1965, that (I) (we) last saw the deceased alive on July 7th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
M. Paul Byerly							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M. Paul Byerly				5820 York Rd Baltimore 12 Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/10/65		New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUL 9 1965				Robert E. Taylor			
25C. FUNERAL DIRECTOR				ADDRESS			
Ellsworth Armacost				Ellsworth Armacost 4600 Liberty Heights			

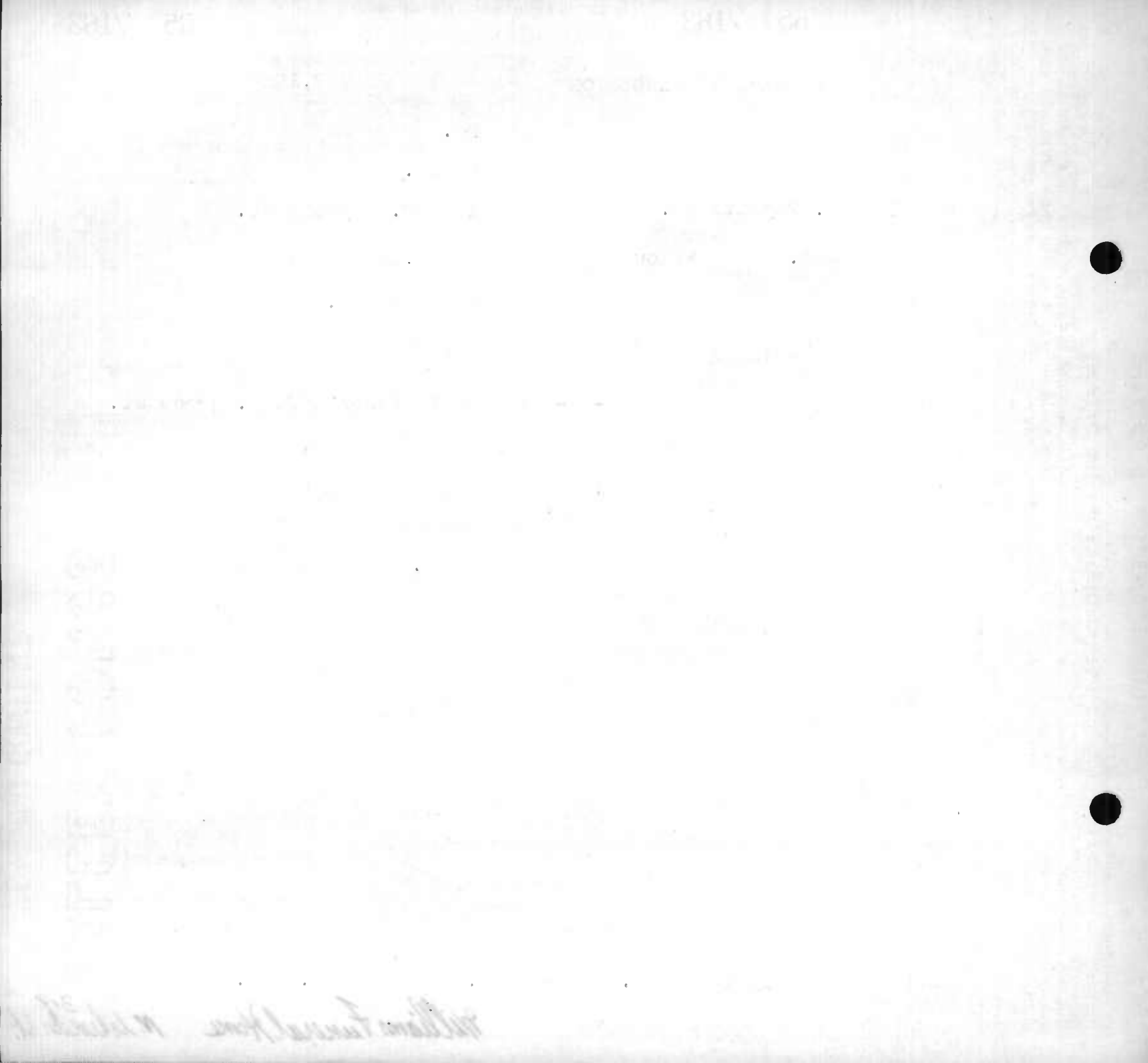
S2K

S2K

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7163	
BIRTH NO. 65 7163		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HERBERT PENDLETON		JULY 7, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>1609 W. Fayette St.</i>			A. STATE Md.		
			B. COUNTY 19-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Balto.		
			D. STREET ADDRESS (If rural, give location)		
			1609 W. Fayette St.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Col.	Widow	June 9, 1891	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer			Culpeper Va.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Louis Pendleton			Annie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			216-03-5413		Pearl Gibson 1528 N. Bruce St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
<p>I</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p>(A) DUE TO <i>Generalized arteriosclerosis</i></p> <p>(B) DUE TO <i>prob. Ca. of Lung</i></p> <p>(C) <i>Chronic Heart failure</i></p>		<p><i>2 mo</i></p> <p><i>1 year</i></p>
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-12-65</i> to <i>7-7-65</i> , that (I) (we) lost saw the deceased alive on <i>7-7-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. Nakagawa</i>				23B. DATE SIGNED <i>7-8-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>HIROSHI NAKAGAWA</i>				23D. ADDRESS <i>521 W. Lexington St Balto</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		July 10 '65		Mt. Auburn Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 9 1965		<i>Robert E. Taylor, M.D.</i>		<i>Williams Funeral Home 318 N. Scholander St.</i>	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)~~PERLUE~~ PERLUE HALL

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1965 4:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pikesville 53-00

D. STREET ADDRESS (If rural, give location)

Woodholme Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

4/13/18

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WEST VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JESSE HALL

14. MOTHER'S MAIDEN NAME

LAKIE CASEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.

232186617

17. INFORMANT

ADDRESS

ROSIA HALL PIKESVILLE, MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Driveway

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Woodholme Avenue, Pikesville

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 1 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/11/65

23C. NAME of CEMETERY or CREMATORY

CRAIG CEMETERY

23D. LOCATION

(City, town, or county)

(State)

POWELLTON, WEST VIRGINIA

24A. DATE REC'D BY HEALTH DEPT.

JUL 9 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HOWARD H. HUBBARD 4107 WILKENS AVE. 21229

WALLACE PIERCE

Charles R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				65 7165		65 7165		Hane, Clarence William		July 2, 1965 4:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				Pennsylvania				Pottstown			
D. STREET ADDRESS (If rural, give location)				RT 1 Pottstown				V-35			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days	
Male		Caucasian		Never Married		9/14/11		53		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Janitor				Unknown				Pennsylvania			
12. CITIZEN OF WHAT COUNTRY?				U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
William, Hane				Olaa Moses							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
Yes 5/2/42 to 1/31/46				163 30 9570				Veterans Hospital Records Baltimore, Maryland 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)				(A) DUE TO				Acute purulent meningitis, one day			
ANTECEDENT CAUSES				(B) DUE TO				Chronic purulent otitis media, 6 months			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pulmonary tuberculosis, far advanced, active, Tuberculous enteritis.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				Yes		Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from July 1, 1965 to July 2, 1965, that (X) (we) last saw the deceased alive on July 2, 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Young E. Chun, M.D.				July 2, 1965							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Young E. Chun				Veterans Hospital, Balto., Md.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
Burial		July 7, 65		Bethel Cemetery		East Coventry Township, Pennsylvania					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS							
JUL 9 1965		Robert E. Farley, M.D.		Wm. Cook Brooks Towson 1050 York Road		Towson, Maryland 21204					

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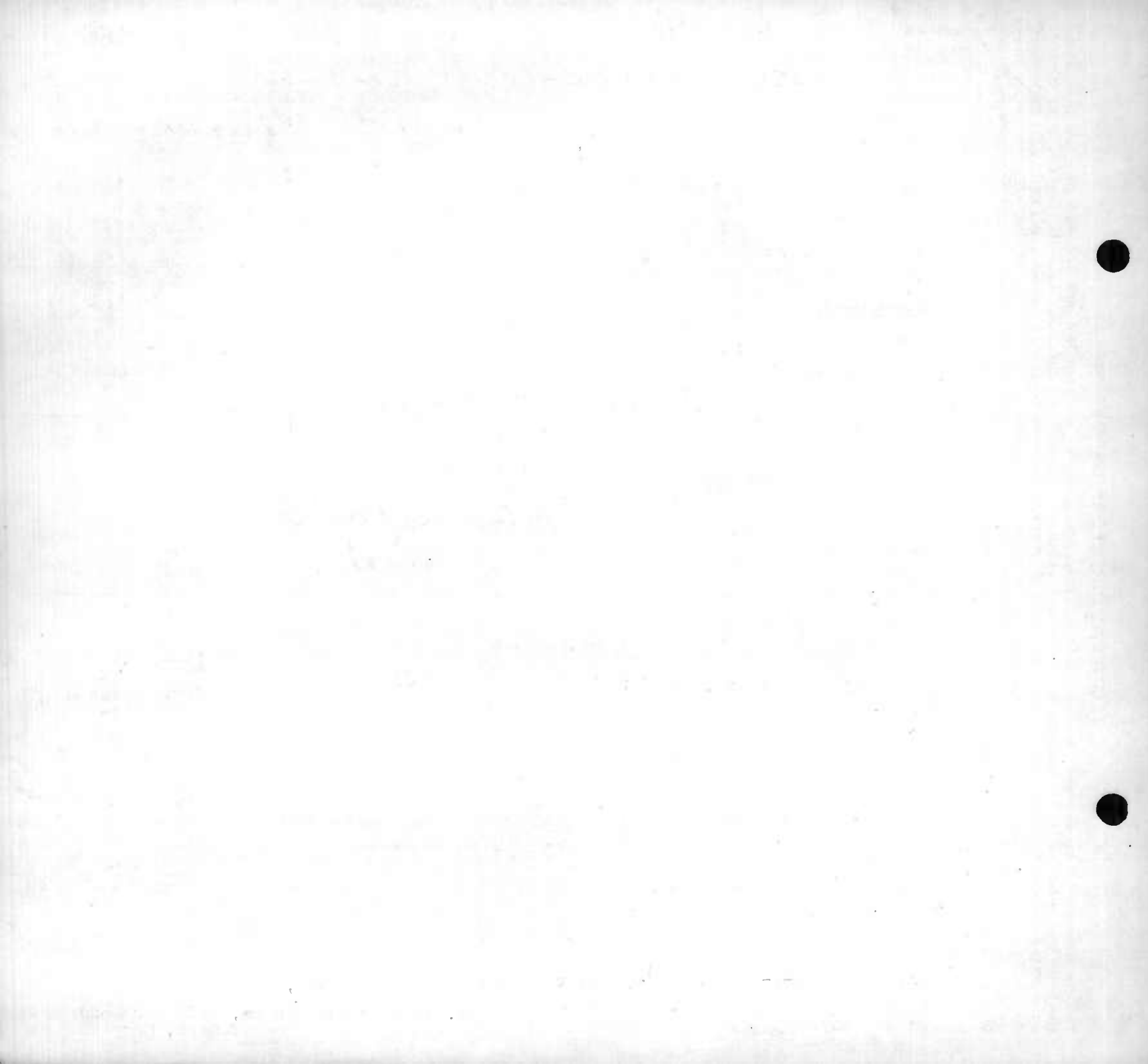
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

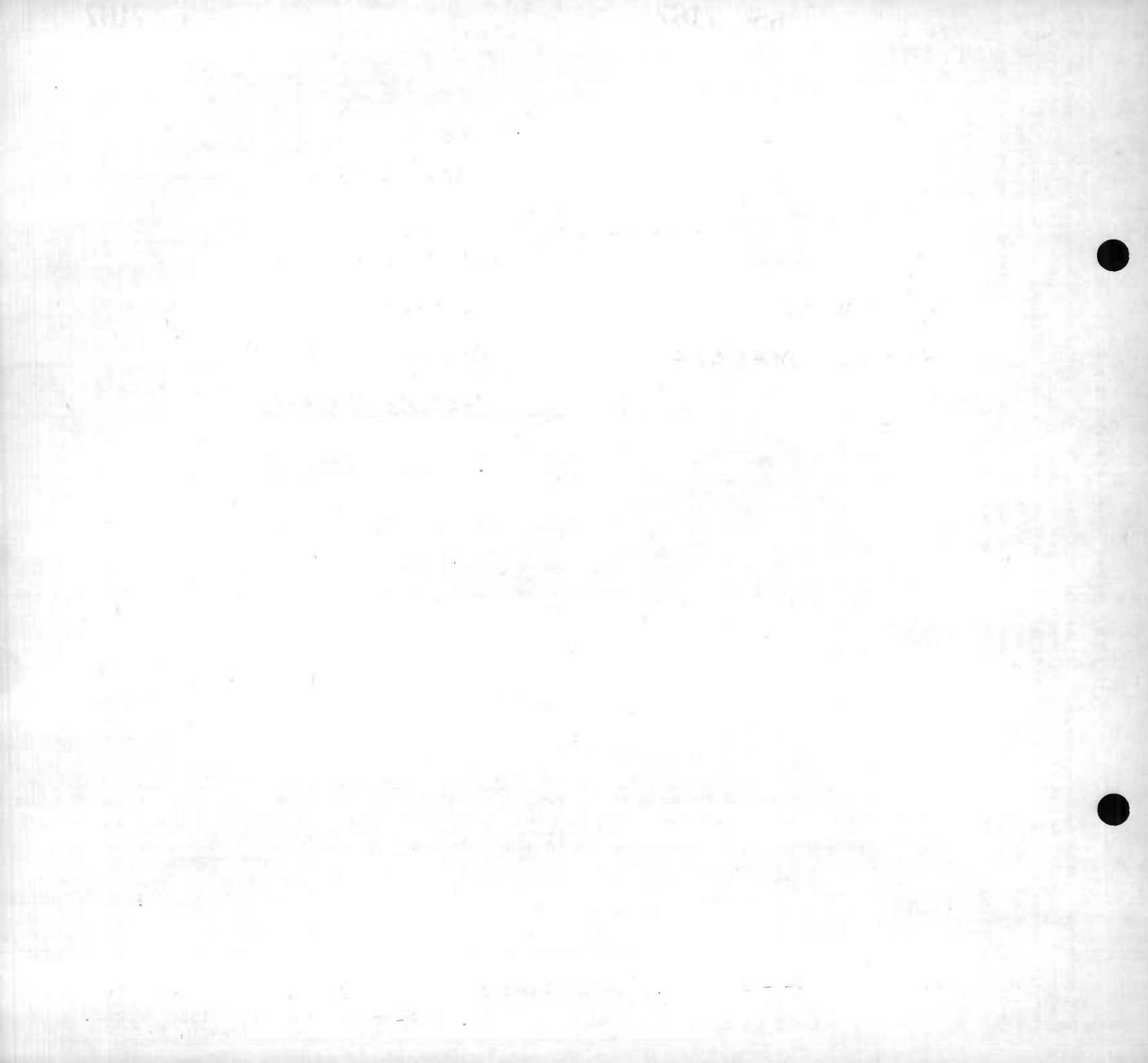
Baltimore City Health Department				Registered No.	
BIRTH NO. 11637 65 7166		CERTIFICATE OF DEATH		65 7166	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELSIE FENRICH		2. DATE AND HOUR OF DEATH 7-3-65 1:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL 36			A. STATE MARYLAND B. COUNTY HALLLENDALE PARK BAL CO.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 34 53.00		
			D. STREET ADDRESS (If rural, give location) 1612 ORLANDO ROAD		
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	B. DATE OF BIRTH 11/12/02	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN KLAPP		
14. MOTHER'S MAIDEN NAME ELIZABETH JORDON			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		
16. SOCIAL SECURITY NO. 220-14-1355			17. INFORMANT ADDRESS HOSPITAL RECORDS		
18. I 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) hemicpercardium DUE TO (B) metastases from Ca DUE TO (C) of breast		
INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 2 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA BREAST		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 2 1965 to July 3 1965 , that (I) (we) last saw the deceased alive on July 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jacinto V. de Boya				23B. DATE SIGNED July 3, 1965	
23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BOYA				23D. ADDRESS FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-65		24C. NAME of CEMETERY or CREMATORY Dulany Valley Cemetery	
24D. LOCATION (City, town, or county) (State) Timonium, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. Cook Brooks Towson, 1050 York Road Towson, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

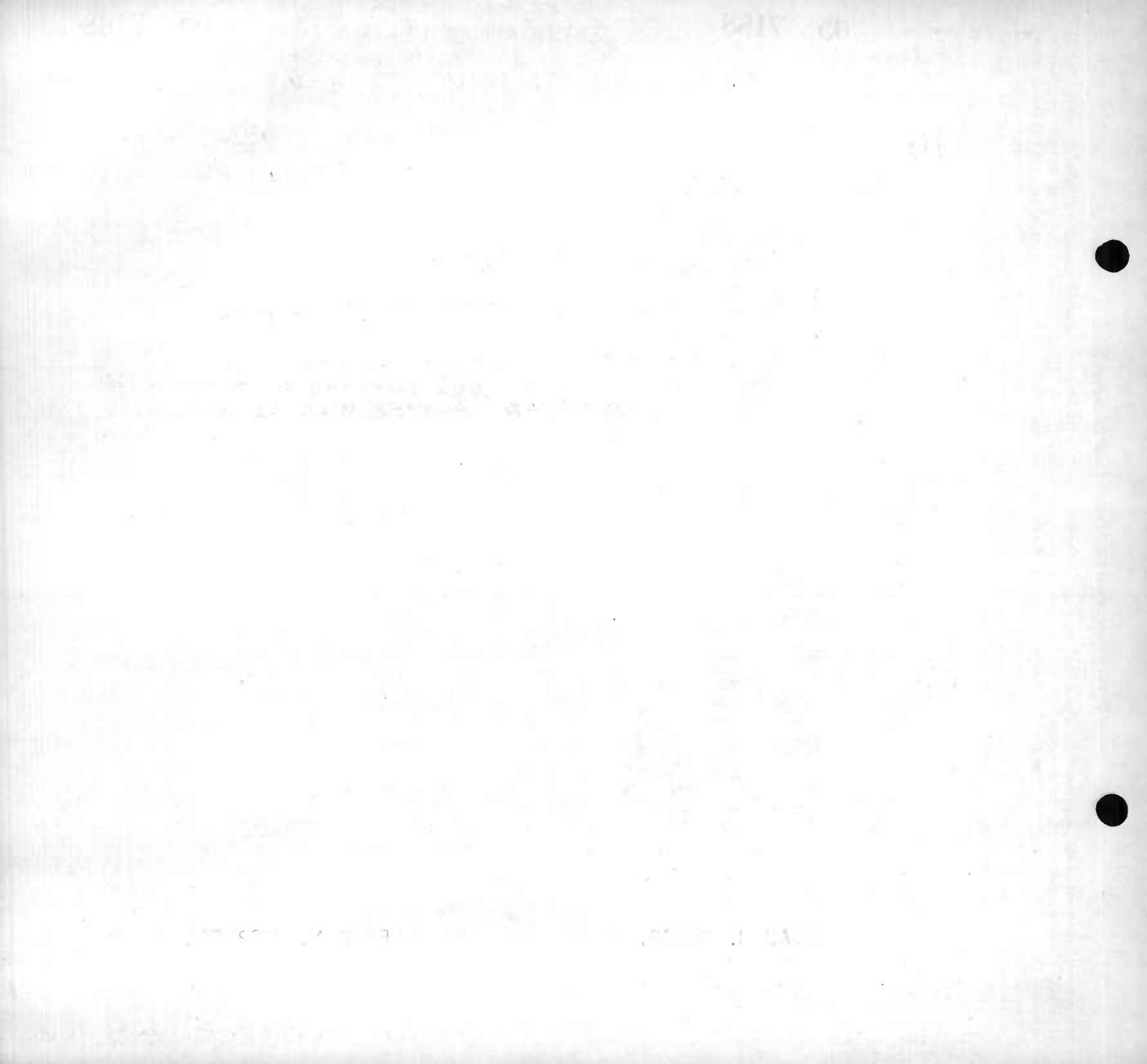
BIRTH NO. 65 7167		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7167	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 7-3-65 3:00 P.M.	
1. NAME OF DECEASED (Type or Print) <i>Mamie Spira</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Melchor Nursing Home</i>		A. STATE <i>MD</i> B. COUNTY <i>Balto</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>WHITEHALL</i>			
		D. STREET ADDRESS (If rural, give location) <i>5300</i>			
5. SEX <i>Fe</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>OCT 23, 1889</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>ITALY</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>ANTINO MASCI</i>		14. MOTHER'S MAIDEN NAME <i>MARY</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>CHARLES F. SPERA</i>	
18. <i>332X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>CEREBRAL THROMBOSIS</i>		<i>WEEKS</i>	
ANTECEDENT CAUSES		(B) DUE TO <i>ARTERIOSCLEROSIS</i>		<i>YEARS</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 1st</i> 19 <i>65</i> to <i>July 2nd</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Lucy A. G. M.D.</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/3/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>LUCY A. ELIAS, M.D.</i>		23D. ADDRESS <i>6714 QUEENS FERRY RD BALTO. 12</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-7-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Josephs Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Texas, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson</i>	
				ADDRESS <i>1050 York Rd. Towson, Maryland</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

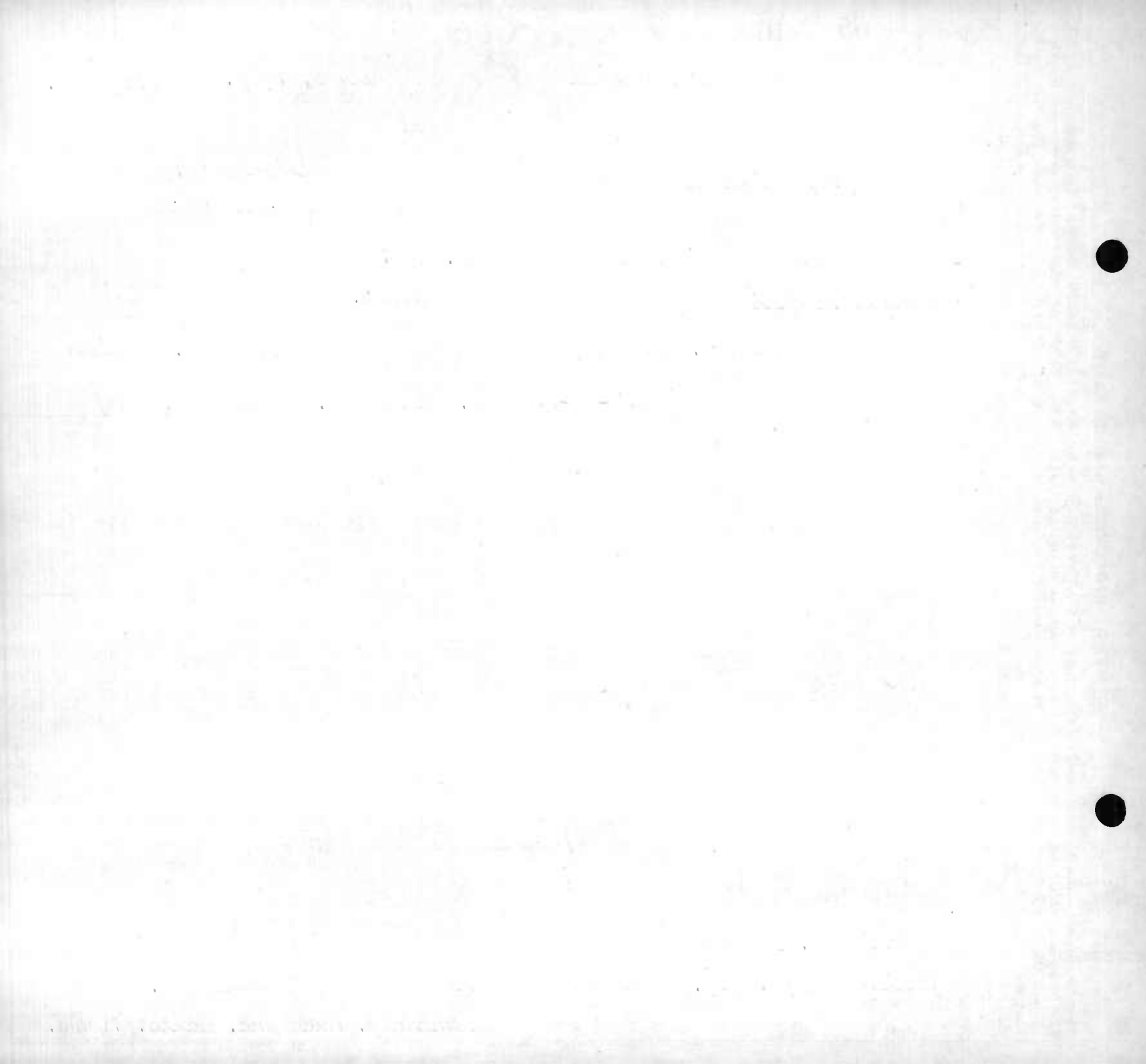
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 7168				
BIRTH NO. 65 7168					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>CALLAHAN, Frederick Stephen</u>					2. DATE AND HOUR OF DEATH <u>7-4-65</u> <u>11:25</u> <u>A</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> (If not in hospital or institution, give street address or location)					A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>College Manor, Futherville, Md.</u>				
					D. STREET ADDRESS (If rural, give location) <u>53-00</u>				
5. SEX <u>M</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-20-1880</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISTRICT MANAGER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>OIL COMPANY</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Michael Sidney Callahan</u>			14. MOTHER'S MAIDEN NAME <u>Anelia Butler Callahan</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>092-05-9471</u>		17. INFORMANT ADDRESS <u>MRS DOROTHY EICHELBERGER HUNTER MILL RD. WHITEHALL 21161</u>				
18. <u>450-1</u> I			CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) <u>Pneumonia</u> DUE TO						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Surgery, confinement</u> DUE TO						
			(C) <u>to bed.</u>						
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>None</u>						
19A. DATE OF OPERATION <u>6-29-65</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gangrenous RT. foot</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6-3-1965</u> to <u>7-4-1965</u> , that (I) (we) last saw the deceased alive on <u>7-4-65</u> at <u>12:20 AM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Brian H. Gross</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-4-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>BRIAN H. GROSS,</u> M.D.					23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-6-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>PROSPECT HILL</u>		24D. LOCATION (City, town, or county) (State) <u>TOWSON, Md #4</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>WM COOK, BROOKS TOWSON, 1050 YORK RD</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 7169					
BIRTH NO. 65 7169					M.E. CASE NO.					
1. NAME OF DECEASED (Type at Print) Carol Jean Kerndl					2. DATE AND HOUR OF DEATH July 8, 1965. 11:30 A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3107 Clifftmont Avenue					A. STATE Md					
					B. COUNTY 8-01					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)					
Baltimore # 13					3107 Clifftmont Avenue					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH Oct. 2, 1930	9. AGE (In years last birthday) 34	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles A. Kerndl					14. MOTHER'S MAIDEN NAME Catherine W. Beacham					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-30-1176		17. INFORMANT Mr. Charles A. Kerndl		ADDRESS (Same)			
18. 175.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
					(A) Generalized Carcinomatosis DUE TO			1 yr.		
			(B) Carcinoma of the DUE TO			1 yr.				
			(C)							
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION Feb 1965			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 15 19 65 to July 8 19 65 , that (I) (we) last saw the deceased alive on July 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE William L. Fearing					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 7-9-65		
23C. PHYSICIAN'S NAME (Type) William L. Fearing					23D. ADDRESS 3025 Belair Rd, Balto 13 Md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/12/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965			25B. NAME OF REGISTRAR Robert E. Fearing			25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. 14 Md.			ADDRESS	

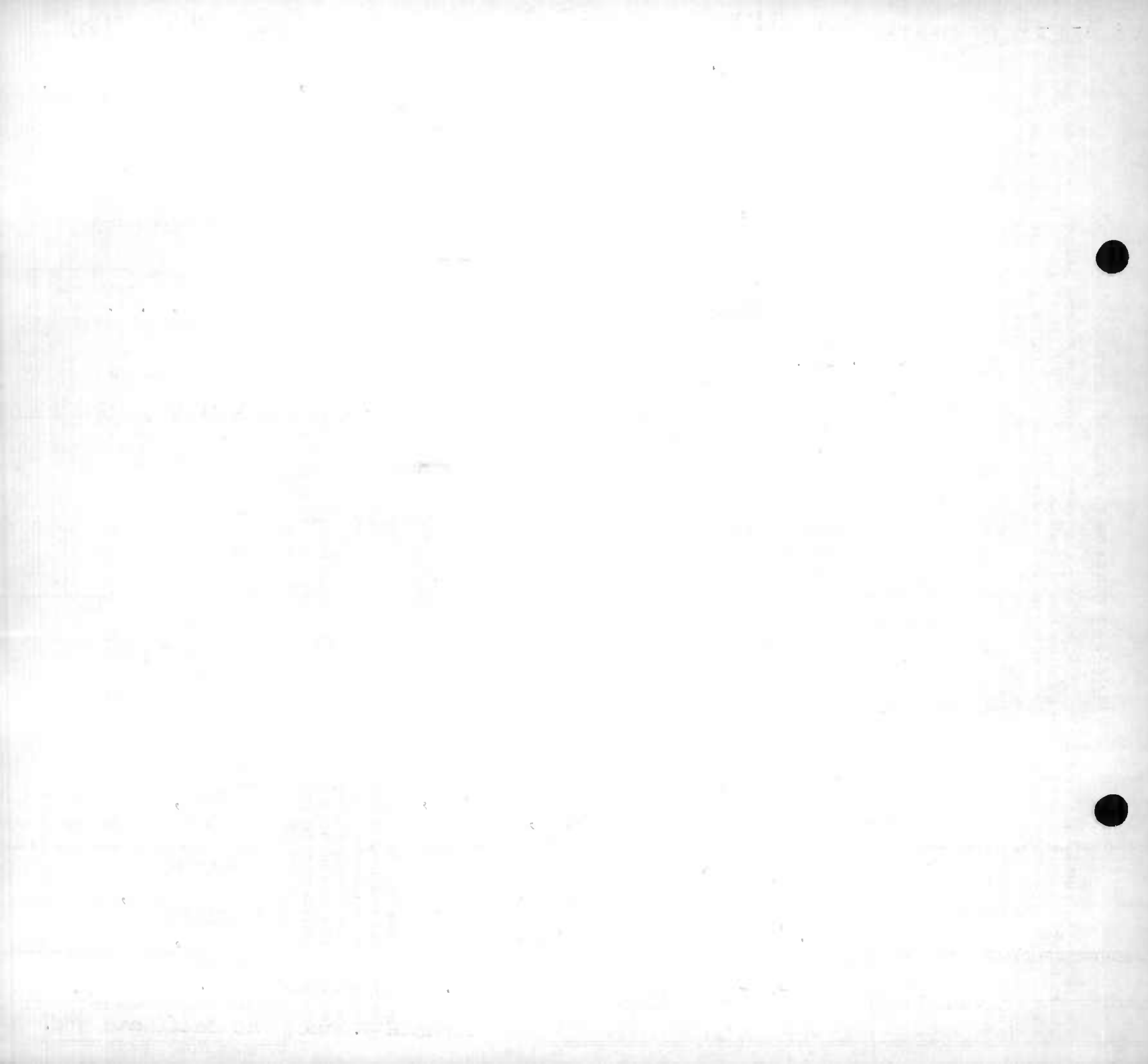


LS: 27-53-88

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

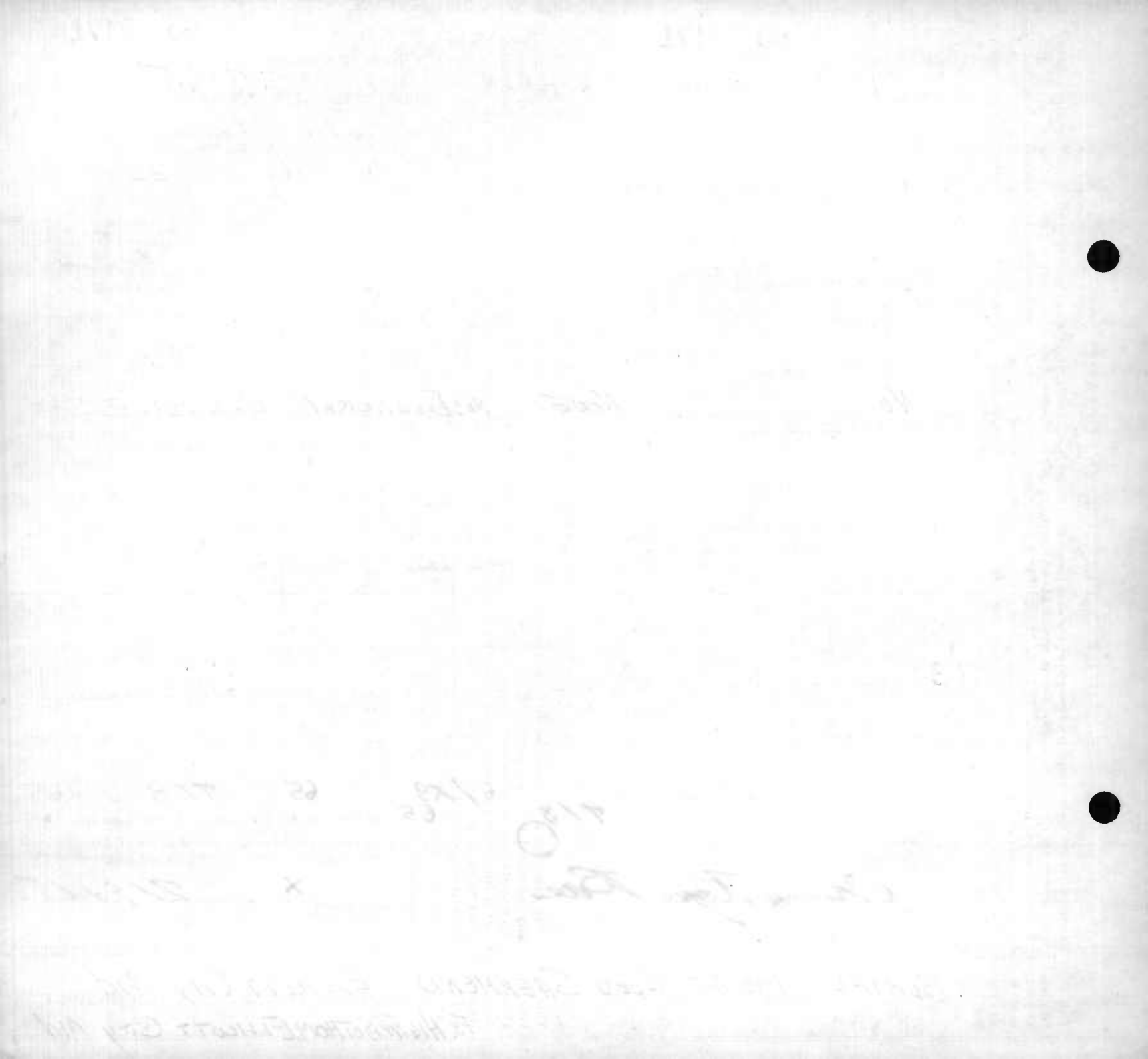
BIRTH NO. 65 7170		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7170	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mary E. Satterfield			2. DATE AND HOUR OF DEATH July 8, 1965 7:05 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4940 Eastern Avenue #21224		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8-8-01	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME John N. Furlong		
14. MOTHER'S MAIDEN NAME Not known			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 450.01 Pulmonary Embolus 1 Hour			CAUSE OF DEATH (A) DUE TO Arteriosclerosis (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Sigmoid Volvulus 1 Week		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 9, 1960 to July 8, 1965, that (I) (we) last saw the deceased alive on July 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald Baltzan			23B. DATE SIGNED July 8, 1965		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Dr. Donald Baltzan			23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7-12-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1965			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 7171	
BIRTH NO. 65 7171		M.E. CASE NO. 65 15938		1. NAME OF DECEASED (Type or Print) THOMAS EUGENE BARKER		2. DATE AND HOUR OF DEATH 6:50 7-8-65 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location 34 BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ellicott City 63-20 D. STREET ADDRESS (If rural, give location) 105 Frederick Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 6/29/65	9. AGE (In years last birthday) 9	If Under 1 Yr. Months: 9 Days: 10 Hours: 50		If Under 24 Hrs. Min. 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELMER C. BARKER				14. MOTHER'S MAIDEN NAME ELEANORA HAMILTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS MRS. ELEANORA F. BARKER, F.C. Md.			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 7-54-2 I CARDIAC INSUFFICIENCY DUE TO INTERVENTRICULAR SEPTAL DEFECT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATELECTASIS, BILATERAL ANNULAR PANCREAS				INTERVAL BETWEEN ONSET AND DEATH 9 days same same			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION July 4, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INT. OBSTRUCTION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/29 19 65 to 7/8 19 65 , that (I) (we) last saw the deceased alive on 7/8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chung Kye Bae M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-10-65		24C. NAME of CEMETERY or CREMATORY GOOD SHEPHERD		24D. LOCATION (City, town, or county) (State) ELLICOTT CITY Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS F. CHILDS BOTTOM ELICOTT CITY Md.			



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

INEZ McINTOSH

2. DATE AND HOUR PRONOUNCED DEAD

7/7/65 2:45 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

46

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5111 Baltimore Nat'l Pike

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

August 18 1895

9. AGE (In years
last birthday)

69

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Twenty First Bridge Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James D. Clark

14. MOTHER'S MAIDEN NAME

Ally Ravenscroft.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

Mrs. Joseph E. Geatz Cumberland Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Abdominal cancer (probably pancreas)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/10/65

23C. NAME of CEMETERY or CREMATORY

Dawson Cem.

23D. LOCATION (City, town, or county)

Rawlings Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Fadden

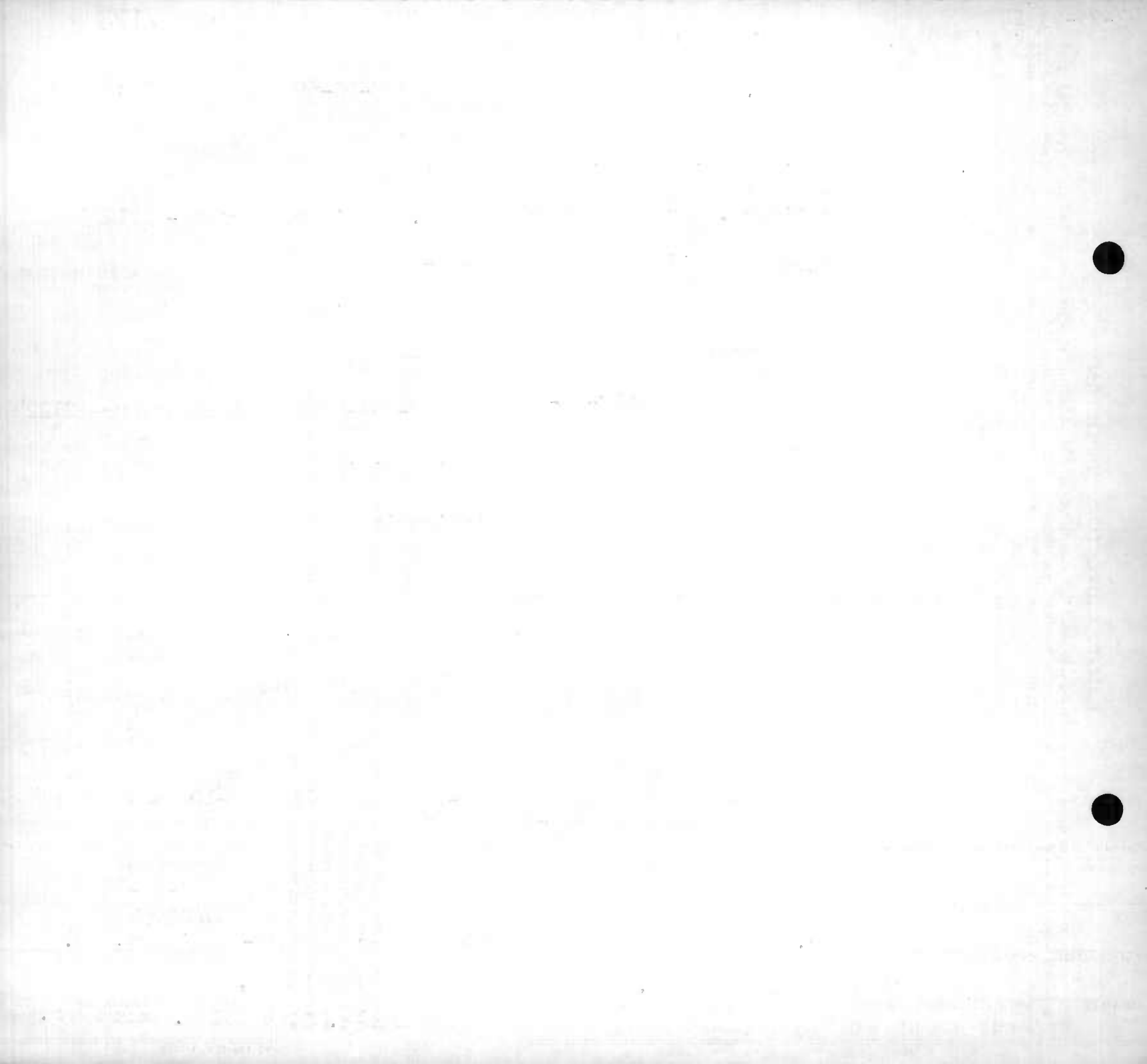
24C. FUNERAL DIRECTOR

Louis Sten Inc. Cumberland Md.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

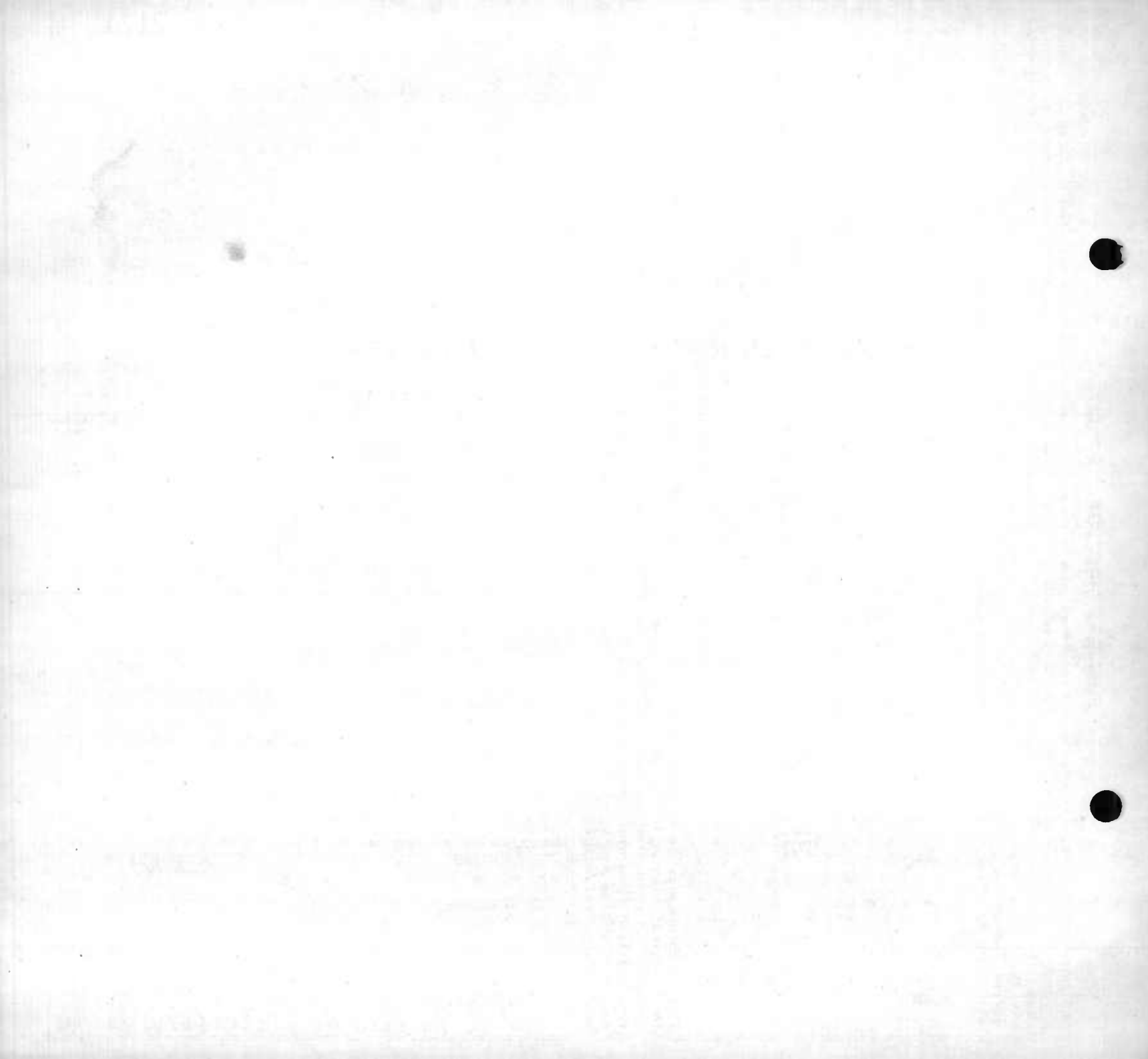
BIRTH NO. <u>B-652</u>		65 7173		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 7173</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Leatha L. Branch</u>				2. DATE AND HOUR OF DEATH <u>7-10-65</u> <u>12:40</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland #21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>18-03</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				D. STREET ADDRESS (If rural, give location) <u>947 W. Baltimore Street - #21223</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-31-14</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Andrew Turner</u>				14. MOTHER'S MAIDEN NAME <u>Addie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>219-20-7390</u>		17. INFORMANT ADDRESS <u>RECORDS-BCH-4940 Eastern Avenue-#21224</u>		
18. <u>252.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Thyrototoxic Crisis</u> CAUSE OF DEATH (A) <u>Thyrototoxic Crisis</u> DUE TO (B) <u>Thyrototoxicosis</u> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Urinary Tract Infection</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> <u>19 65</u> to <u>7-10</u> <u>19 65</u> , that (I) (we) lost saw the deceased alive on <u>7-10</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-10-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Howard Rathbun</u>				23D. ADDRESS <u>#21224</u> <u>4940 Eastern Avenue-Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/13/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1965</u>		25B. NAME OF REGISTRAR <u>R. E. Faldut</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u>		ADDRESS <u>661 W. Barre St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

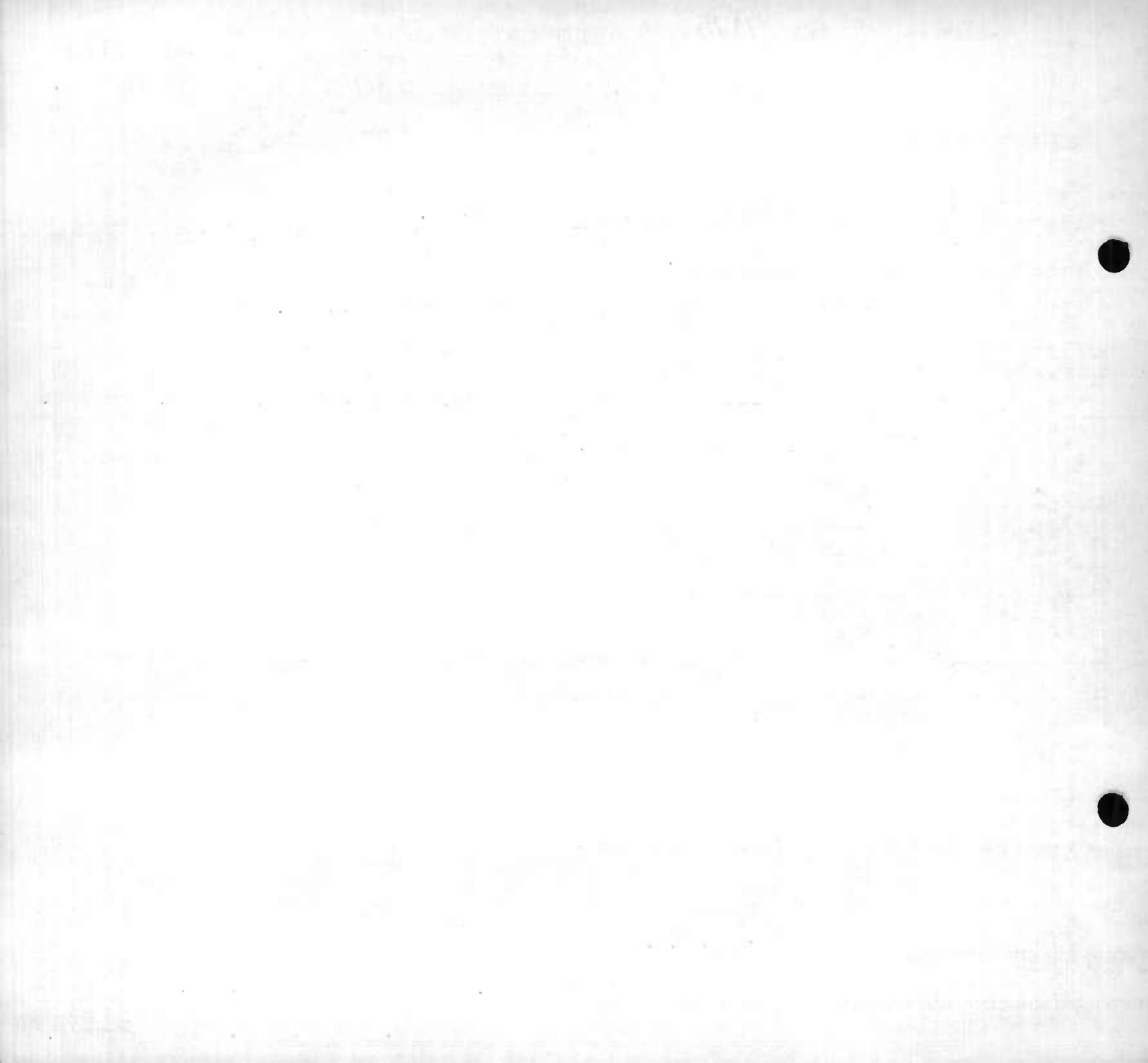
BALTIMORE CITY HEALTH DEPARTMENT									
65 7174									
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>Elizabeth Mitchell</i>					2. DATE AND HOUR OF DEATH <i>7-11-65 1:04 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 BON SECOURS HOSP</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>20-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <i>2400 W Lombard St.</i>				
5. SEX <i>F</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>11-29-08</i>	9. AGE (In years last birthday) <i>56</i>	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>HURDIE BURLEY</i>					14. MOTHER'S MAIDEN NAME <i>ROBERTA WATTS</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>SHIRLEY MITCHELL</i>		ADDRESS		
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>Acute pulmonary Edema.</i> DUE TO (B) <i>Hypertensive C.V.D.</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <i>AF</i> (this hospital) attended the deceased from <i>July 11, 1965</i> to <i>July 11, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <i>AF</i> (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Jose F. Morelos</i> M.D.					23B. DATE SIGNED <i>7/11/65</i>				
23C. PHYSICIAN'S NAME (Type) <i>JOSE F. MORELOS</i> M.D.					23D. ADDRESS <i>B.S.H.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>7/14/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary</i>			24D. LOCATION (City, town, or county) (State) <i>Brooklyn, Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>			25C. FUNERAL DIRECTOR <i>Charles A. Rice</i> 661 W. Barre St				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.		65 7175		CERTIFICATE OF DEATH		Registered No.		65 7175	
1. NAME OF DECEASED (Type or Print) Jeremiah Fowler						2. DATE AND HOUR OF DEATH 7/7/65 3:12 a. m.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 South Baltimore General Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2403 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 215 E. Cross Street							
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M.		8. DATE OF BIRTH 7/19/98		9. AGE (In years last birthday) 66		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10B. KIND OF BUSINESS OR INDUSTRY Railroad				11. BIRTHPLACE (State or foreign country) Calvert Co., Md.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Sutton Fowler						14. MOTHER'S MAIDEN NAME Dehlia Thomas							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Rosamae Fowler 215 E. Cross St							
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) Cerebrovascular accident DUE TO (B) Hypertensive cardiac DUE TO vascular disease (C)				INTERVAL BETWEEN ONSET AND DEATH 1 day			
						OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Arteriosclerosis							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (the physician) attended the deceased from 7/7/65 19 to 7/7/65 19, that (I) (we) last saw the deceased alive on 7/7/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.													
23A. SIGNATURE Romulo V. Goco M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>						23B. DATE SIGNED 7/8/65							
23C. PHYSICIAN'S NAME (Type) ROMULO GOCO, M.D.						23D. ADDRESS 5500 Bowleys Run, Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/65		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965				25B. NAME OF REGISTRAR Robert E. Jarboe				25C. FUNERAL DIRECTOR JOHN F. DENNY, INC. 715 Light St.					



FUNERAL DIRECTOR: IMPORTANT

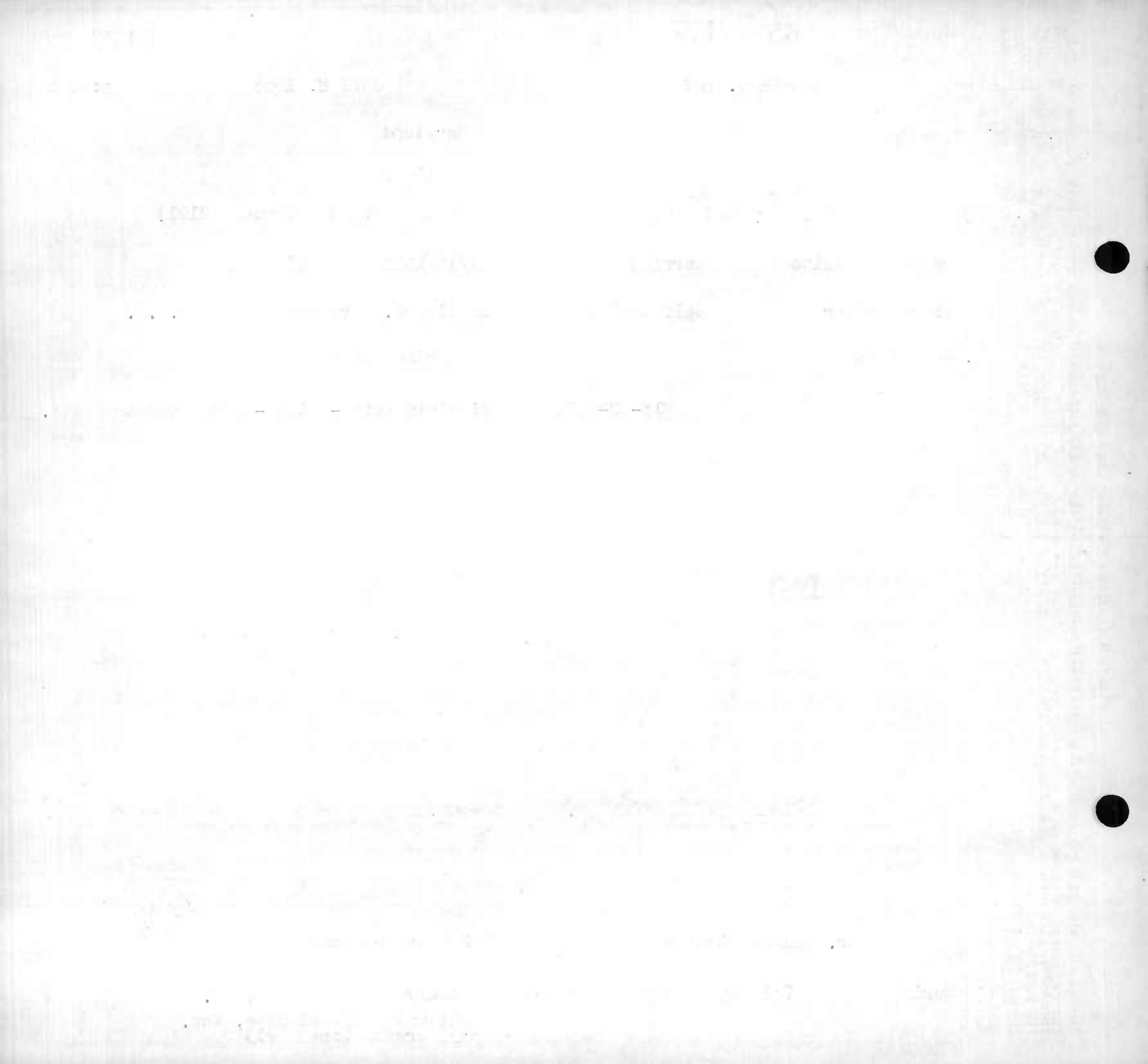
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7176				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7176	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lillian A. Lentz</i>				2. DATE AND HOUR OF DEATH <i>July 8, 1965 5:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>QUINCY HOME AND HOSPITAL</i>				A. STATE <i>MARYLAND</i> B. COUNTY <i>6-02</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
				O. STREET ADDRESS (If rural, give location) <i>2 N. LAKEWOOD AVE</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>12-13-05</i>		9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>EDWARD J. MORAN</i>				14. MOTHER'S MAIDEN NAME <i>LILLIAN SIMPSON</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>J. Albert Lentz, 2 N. Lakewood Avenue #24</i>	
18. <i>420.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>lobar pneumonia</i>				CAUSE OF DEATH (A) <i>chronic pulmonary insufficiency due to pulmonary fibrosis</i> (B) <i>chronic congestive heart failure due to N.I. and A.H.D.</i> (C) <i>facture due to N.I. and A.H.D.</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 7, 1965</i> to <i>July 8, 1965</i> , that (I) (we) last saw the deceased alive on <i>July 8, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. Nahum</i>				M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7. 8. 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>A. NAHUM</i>				23D. ADDRESS <i>Church Home & Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/12/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		ADDRESS <i>3331 Brehms Lane #13</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

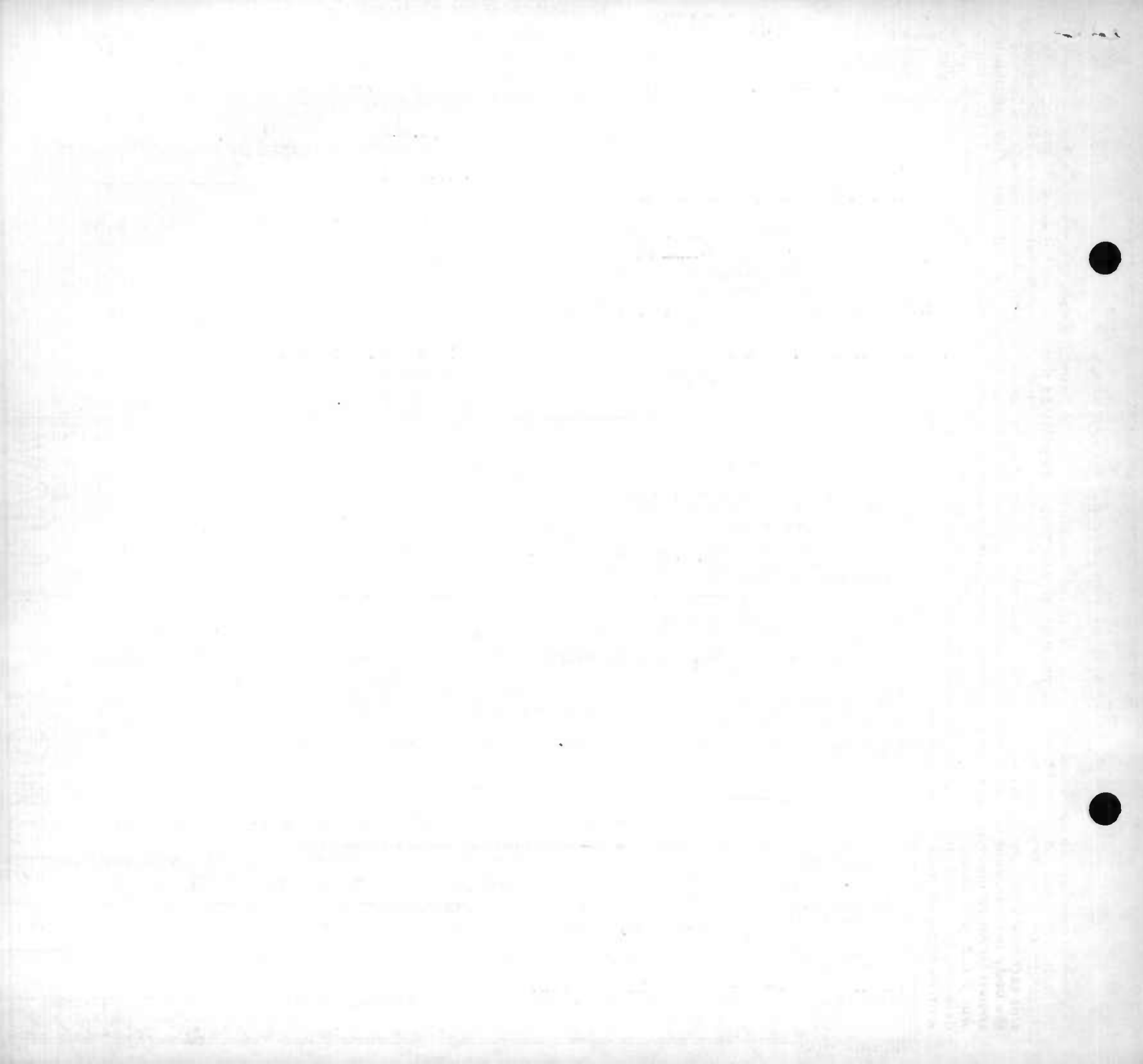
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7177	
BIRTH NO. 65 7177		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANDREW G. LOTZ		2. DATE AND HOUR OF DEATH JULY 8, 1965 5:50 a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-01			
FULL NAME OF HOSPITAL OR INSTITUTION 3300 Woodstock Avenue Baltimore, Maryland 21213		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3300 Woodstock Avenue 21213			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 11/19/1911	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Lotz		14. MOTHER'S MAIDEN NAME Catherine Cuneo	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 215-07-9970		16. SOCIAL SECURITY NO. 215-07-9970		17. INFORMANT Virginia Lotz - wife - 3300 Woodstock Ave.	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of lung DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 mo			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ante senile dementia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to July 8 1965 , that (I) was lost saw the deceased alive on July 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Conrad Richter M.D.				23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type) Dr. Conrad Richter				23D. ADDRESS 3128 Harford Road M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 12 1965		24F. NAME OF REGISTRAR Robert E. Faldut	
24G. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		24H. ADDRESS 3331 Brehms Lane #13			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 7178					Registered No. 65 7178				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Grace G. Bateman					2. DATE AND HOUR OF DEATH 7-8-65 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-36				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1321 Broening Hwy				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (Specify)		8. DATE OF BIRTH 1-28-1897	9. AGE (In years last birthday) 68	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10B. KIND OF BUSINESS OR INDUSTRY A.T. Jones		11. BIRTHPLACE (State or foreign country) Lynchburg Va		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Charles V. Wright					14. MOTHER'S MAIDEN NAME Grace G. Wright				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Ill yes, give war or dates of service			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Bateman 1321 Broening Hwy				
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HYPERTENSIVE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARDIOVASCULAR DISEASE DIABETES MELLITUS					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC PYELOECYSTITIS									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from DEC 19 19 63 to July 6 19 65 , that (I) (we) last saw the deceased alive on July 6 - 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
23A. SIGNATURE Enrique A. Herrera M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 8 - 1965		
23C. PHYSICIAN'S NAME (Type) ENRIQUE A. HERRERA M.D.					23D. ADDRESS 1001 DUNDALK AVE. MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-65		24C. NAME of CEMETERY or CREMATORY Spring Hill		24D. LOCATION (City, town, or county) (State) Lynchburg Va			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Walter Dabrowski		ADDRESS 1005 Dundalk Ave			



1

65 7179

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7179

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MELVIN J. KODENSKI, SR.

2. DATE AND HOUR PRONOUNCED DEAD 7/9/65 3:35 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY

5. SEX male 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH FEB. 8, 1916 9. AGE (In years last birthday) 49

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAVERN OWNER 10B. KIND OF BUSINESS OR INDUSTRY TAVERN

11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ALEXANDER KODENSKI 14. MOTHER'S MAIDEN NAME VALERIE GRZYMSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 219-32-0365 17. INFORMANT ADDRESS FRANCES KODENSKI 1614 EASTERN AVE BALTO, MD. 21231

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

Asphyxia

Carbon monoxide poisoning

Conflagration

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house 21C. WHERE DID INJURY OCCUR? 1614 Eastern Ave. 3-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7 9 65 2:40a. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? caught in house fire

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 7/9/65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 7-12-65 23C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY 23D. LOCATION (City, town, or county) (State) BALTIMORE, MD

24A. DATE REC'D BY HEALTH DEPT. JUL 12 1965 24B. NAME OF REGISTRAR Robert E. Parker, M.D. 24C. FUNERAL DIRECTOR ADDRESS Wm. A. Ziolkowski 2007 Eastern Ave. Balto. 31, Md.

MAILED
JAN 11 1964
U.S. AIR MAIL
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THAYER

REINER KODENSKI

IN REPLY TO KODENSKI

NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7180	
BIRTH NO. 65 7180		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DAWIDOWICZ, ALEXANDER		2. DATE AND HOUR OF DEATH July 10, 1965 6:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 41 St. Joseph Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE 26 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26 D. STREET ADDRESS (If rural, give location) 1617 Locust Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/22/93	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car repairman		10B. KIND OF BUSINESS OR INDUSTRY Baltimore & Ohio Railroad		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PHILIP DAWIDOWICZ		14. MOTHER'S MAIDEN NAME JOSEPHINE CHYKACZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-5144		17. INFORMANT ADDRESS 1617 LOCUST ST. BALTO. MD. 21226	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Hypertensive Cardio-vascular (B) Disease. (C) _____			
INTERVAL BETWEEN ONSET AND DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from June 29 1965 to July 10, 1965 , that (I) (we) last saw the deceased alive on July 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Govinda Rao		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 10, 1965	
23C. PHYSICIAN'S NAME (Type) Govinda Rao, M.D.		23D. ADDRESS 1400 N. Caroline St., 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-65		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel County MD		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965			
25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Wm. A. Ziolkowski			
ADDRESS 2007 Eastern Ave. Baltimore, Md.		21231			

BIRTH NO.

65 7181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 7181

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VALERIE MIELCAREK

2. DATE AND HOUR PRONOUNCED DEAD

7/9/65 3:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1614 Eastern Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

SEPT. 8, 1893

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH GRZYMSKI

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

FRANCES KODENSKI

ADDRESS

1614 EASTERN AVE.
BALTO., MD. 21231

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carbon Monoxide poisoning
DUE TO

(C) Conflagration

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1614 Eastern Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 9 65 2:40a. m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK☐☒

21F. HOW DID INJURY OCCUR?

caught in house fire

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-12-65

23C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION

BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Wm. A. Fialkowski, 2007 Eastern Ave., BALTO. 31, MD.

1881 1881

27 1881

WIDOWED

BORN

HONE

HOUSEWIFE

UNKNOWN

JOSEPH GRZYNSKI

FRANK KODENSKI

WORK

NO

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MORRIS E HUNT

2. DATE AND HOUR PRONOUNCED DEAD

7/9/65 11:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1418 S. Hanover St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Feb. 25, 1934

9. AGE (In years
last birthday)

31

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Fireman

10B. KIND OF BUSINESS OR INDUSTRY

Fire Dept.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

William J. Hunt

14. MOTHER'S MAIDEN NAME

Helen Grahe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr. Wm. S. Hunt

ADDRESS

1418 S. Hanover St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7 13 1965

23C. NAME of CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

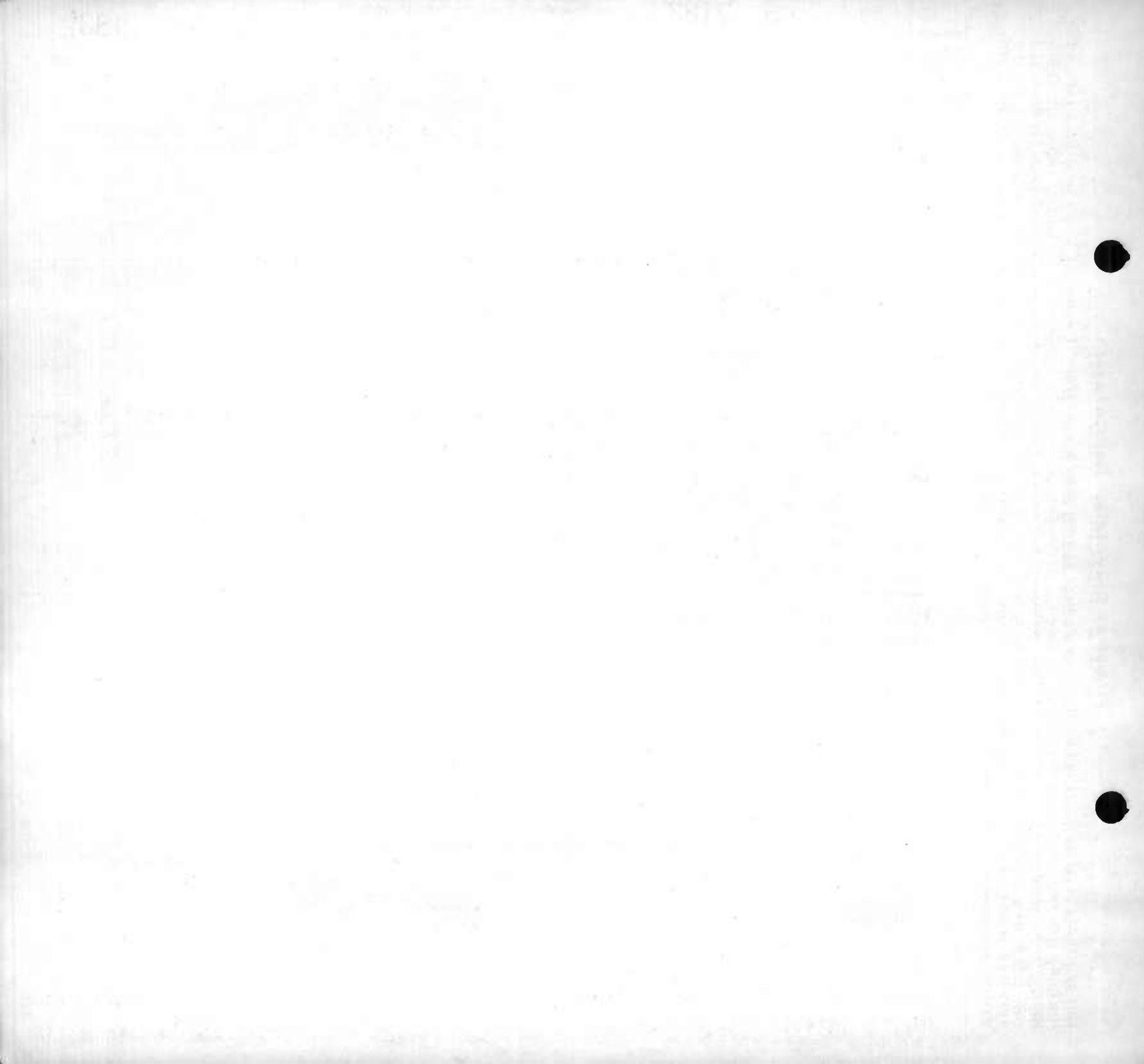
130 E. Fort Ave

WALLLEY PHOTO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 7183					BIRTH NO.					
CERTIFICATE OF DEATH					Registered No. 65 7183					
1. NAME OF DECEASED <i>FLORENCE A WILD</i>					2. DATE AND HOUR OF DEATH <i>JUL 7, 1965 10 AM</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>35 Church Home</i> (If not in hospital or institution, give street address or location)					A. STATE <i>NEW YORK</i>					
					B. COUNTY <i>WATERTOWN</i>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>WATERTOWN V-29</i>					
					D. STREET ADDRESS (If rural, give location) <i>218 N. INDIANA AVE</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>Nov. 24, 1895</i>	9. AGE (In years lost birthday) <i>69</i>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Bookkeeper</i>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Atwell</i>					14. MOTHER'S MAIDEN NAME <i>Evelyn Perh</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph Atwell</i>			
					ADDRESS <i>109 Monmouth</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>332X I</i>					CAUSE OF DEATH (A) DUE TO <i>Cerebrovascular accident</i> <i>2° to cerebral thrombosis</i> (B) DUE TO <i>Probable Subacute bacterial endocarditis</i> (C)					INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>May 19 1965</i> to <i>July 7 1965</i> that (I) (we) last saw the deceased alive on <i>July 7 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Dr. N. N. N. N.</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7. 7. 65</i>			
23C. PHYSICIAN'S NAME (Type) <i>A. N. N. N., M.D.</i>					23D. ADDRESS <i>CHURCH HOME HOSPITAL</i>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>July 8/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Sherburne</i>		24D. LOCATION (City, town, or county)		24E. (State)		
						<i>Sherburne New York</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>William F. ...</i>		ADDRESS <i>...</i>				



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK

SCHADE

2. DATE AND HOUR PRONOUNCED DEAD

July 7, 1965

3:40 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

3304 Yorkway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

12-11-08

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Lever Bros.

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Harry Schade

14. MOTHER'S MAIDEN NAME

Ethel Lyons

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Alphenia Schade 3304 Yorkway 21222

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial/Removal

23B. DATE

7-10-65

23C. NAME of CEMETERY or CREMATORY

Pembroke

23D. LOCATION

(City, town, or county)

(State)

Watertown, Mass

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

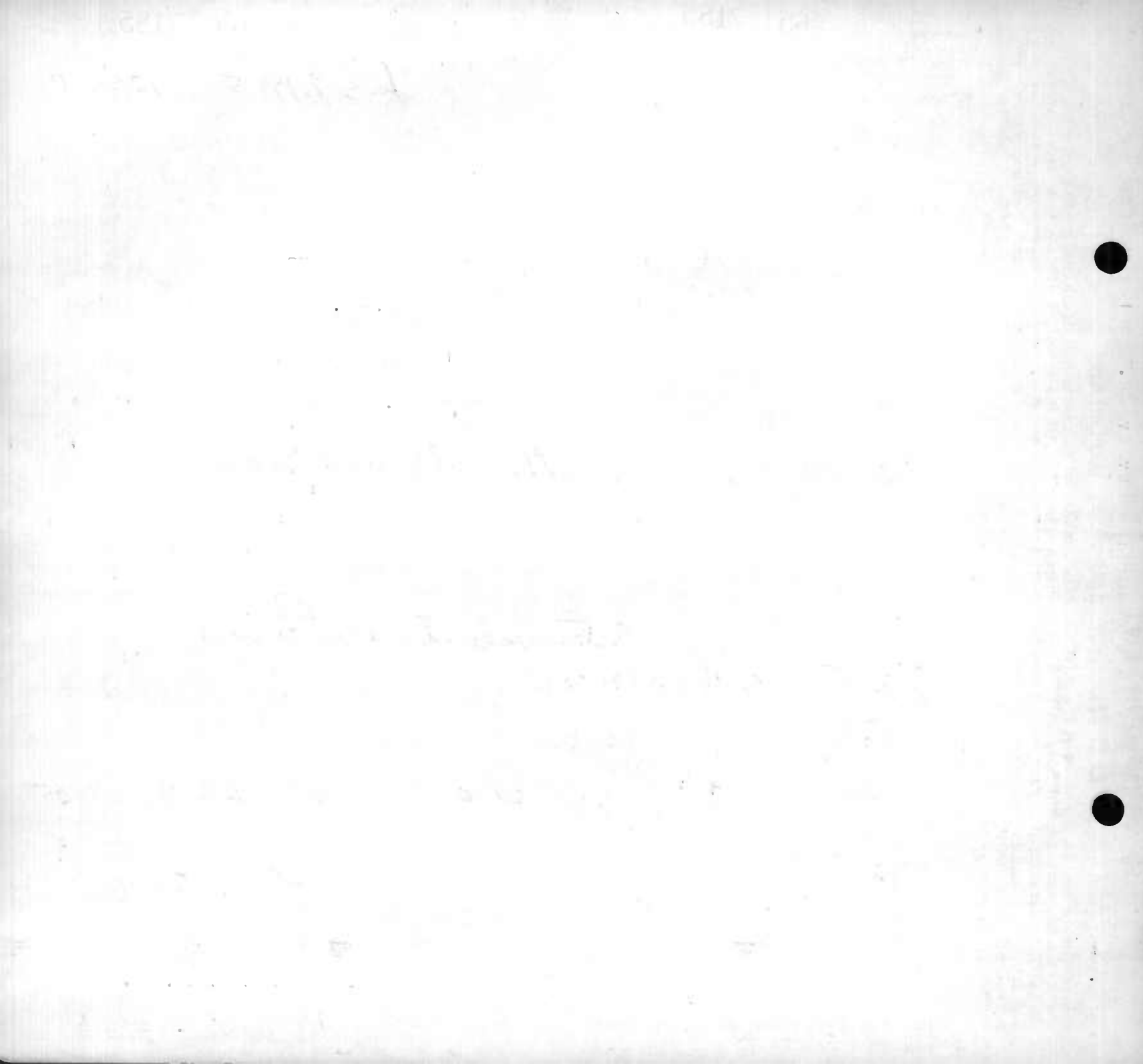
Ullrich Funeral Home Baltimore, Md.

Glenn

RELEASED UNCONDITIONALLY BY DR. BRIETHECKER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

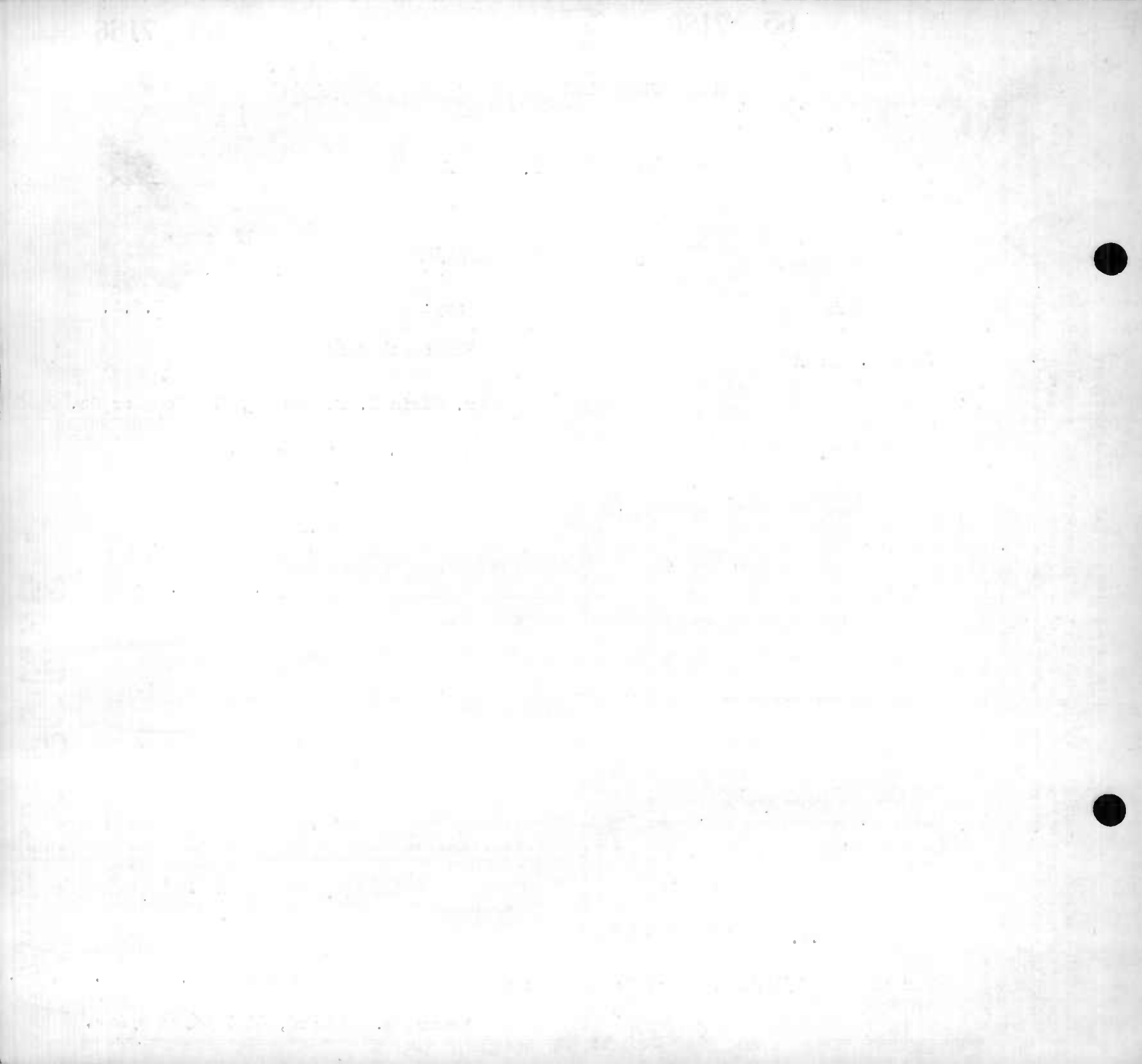
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7185	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Biederman, Maria A.</i>		2. DATE AND HOUR OF DEATH <i>July 9, 1965 12:55 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>24-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1220 RIVERSIDE AVENUE</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>10-26-07</i>	9. AGE (In years lost birthday) <i>58 57</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>GEORGE VOGELSANG</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH LYCETT</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Gustave E. Biederman</i>	
				ADDRESS <i>1220 Riverside Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>410 X I</i>		CAUSE OF DEATH (A) <i>Rheumatic Heart Disease</i> (B) DUE TO (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Arteriosclerotic heart disease</i>			
19A. DATE OF OPERATION <i>7/9/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Mitral Stenosis</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/10, 1965</i> to <i>July 9, 1965</i> , that (I) (we) last saw the deceased alive on <i>7/9/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. R. Gertner</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/9/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. R. GERTNER</i>		23D. ADDRESS M.D. <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7 13 1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>	
25C. FUNERAL DIRECTOR <i>J. C. Kelly</i>		ADDRESS <i>130 E. Fort Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

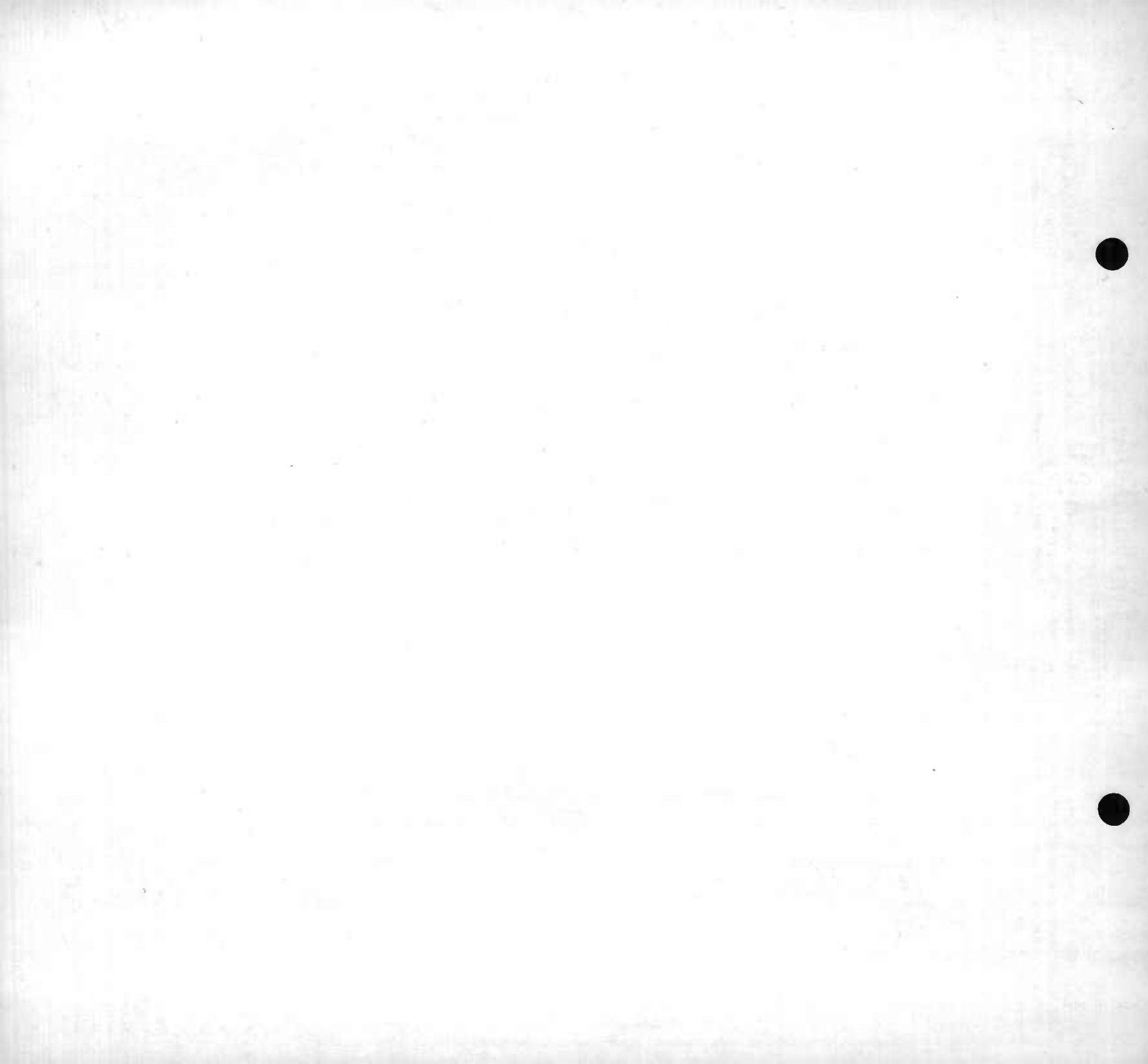
BIRTH NO.		65 7186		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7186	
<div style="display: flex; justify-content: space-between;"> <div> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) ROSE FREDERICK</p> </div> <div> <p>2. DATE AND HOUR OF DEATH July 8, 1965 - 11:30 AM.</p> </div> </div>							
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND LUTHERAN HOSPITAL OF MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 730 ASHBURTON STREET LUTHERAN HOSP. BALTIMORE, MARYLAND</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY ANNE ARUNDEL</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) LYNNBROOK</p> <p>D. STREET ADDRESS (If rural, give location) 632 DOUGLAS STREET</p>			
5. SEX Female	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10/4/89	9. AGE (In years lost birthday) 75 years	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John V. Spann			14. MOTHER'S MAIDEN NAME Elizabeth Geis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT ADDRESS Mr. Edwin B. Frederick, 632 Douglas St. # 25				
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) CEREBROVASCULAR ACCIDENT DUE TO 18 hours</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(B) CEREBRAL HEMORRHAGE DUE TO</p> <p>(C) ARTERIOSCLEROTIC VASCULAR DISEASE</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) —		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<p>22. I certify that (I) (this hospital) attended the deceased from July 7 (9:15 PM) 1965 to JULY 8 (11:30 AM) 1965, that (I) (we) lost saw the deceased alive on July 8 (11:30 AM) 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
23A. SIGNATURE F. S. REROMA				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 8, 1965	
23C. PHYSICIAN'S NAME (Type) F. S. REROMA				23D. ADDRESS LUTHERAN HOSPITAL BALTIMORE MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/1965		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Ave. Balto. 24, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. F. ...		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. # 29			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 7187		CERTIFICATE OF DEATH		Registered No. 65 7187	
1. NAME OF DECEASED (Type or Print) George H. Banks				2. DATE AND HOUR OF DEATH 7.9.65 8:10 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2333 Ivy Ave					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11.18.91	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker			10B. KIND OF BUSINESS OR INDUSTRY Steel			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Banks				14. MOTHER'S MAIDEN NAME HANNAN Clark					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 218-03-5868		17. INFORMANT Victoria Banks			ADDRESS SAME	
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis @ 1 yr				CAUSE OF DEATH (A) DUE TO Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH @ 1 yr			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Pyelonephritis									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Feb 7, 1965 to July 9, 1965 , that (I) (we) last saw the deceased alive on 7.9.65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Charles R. Venter				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7.9.65			
23C. PHYSICIAN'S NAME (Type) Charles R. Venter				23D. ADDRESS 2320 Eutaw Pl					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal July 13/65		24B. DATE July 13/65		24C. NAME of CEMETERY or CREMATORY Smithfield Va.		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Zyrrah T. Elchorn ADDRESS 129 N. Carline St					



LS: 44-01-97

B-653 65 7188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 7188

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Brandt

2. DATE AND HOUR OF DEATH

July 8, 1965 10:30P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2400 Eutaw Place #21217

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-18-89

9. AGE (In years
lost birthday)

75

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown Raum

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #24

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Myocardial Infarction
DUE TO

Immediate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Arteriosclerotic Cardio Vascular Disease
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Gangrene (L) Foot

2 Weeks

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 30, 1965, July 8, 1965,
that (I) (we) last saw the deceased alive on July 8, 1965, and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
DirectorStaff
Phys. ☒

23B. DATE SIGNED

July 8, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Donald Baltzan

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7 12 1965

24C. NAME of CEMETERY or CREMATORY

Holy Cross

24D. LOCATION

(City, town, or county)

(State)

Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

130 E. Fort Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.	
65-7189				65-7189	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			
		CATHERINE KNUDSEN (Catherine Knudsen)			
2. DATE AND HOUR PRONOUNCED DEAD		10 July 1965 (Sat.) 7:33 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY			
43 South Baltimore General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 21230 D. STREET ADDRESS (If rural, give location) 1412 S. Hanover St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
female	caucasian	Married	March 8 1885	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		At Home		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
USA		John Paul Wm. Manner			
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
Phillippina		No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
None		Frederick Knudsen (Husband) Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
420.0 X 260X		Arteriosclerotic heart disease			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO (B) DUE TO (C) DUE TO			
diabetes mellitus					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK [] NOT WHILE AT WORK []			
22. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []		CHIEF MEDICAL EXAMINER [] DATE SIGNED			
ACTUAL EXAMINER'S NAME (Type) Charles S. Petty		M.D. ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER []			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		Mon July 12 65		Western Cem., Balto., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1965		Robert E. Fairley		1400 S. Charles St Baltimore Md 21230	

WALLEY POLICE

CURTIS E. EVANS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7190			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Clinton E. Sevier (Clinton E. Sevier)				7-10-65 Sat 6 20 AM							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland				B. COUNTY 65--2787/194/cee			
43 South Baltimore General Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore 21230			
D. STREET ADDRESS (If rural, give location)				1515 Hanover Street				23-02			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/17/1892	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postman Retired		10B. KIND OF BUSINESS OR INDUSTRY U S Post Office Balto Md So Sta		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph H Sevier				14. MOTHER'S MAIDEN NAME Margaret E Benson							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 46-8246		17. INFORMANT Gertrude Sevier (Wife)		ADDRESS Same					
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH							
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMPHYSEMA				(A) DUE TO							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
(C) ASCUD											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (if this hospital) attended the deceased from 7-2 1965 to 7-10 1965, that (we) lost saw the deceased alive on 7-10 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
23A. SIGNATURE Matthew Z. Kaufmann				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-65					
23C. PHYSICIAN'S NAME (Type) MATTHEW Z. KAUFMANN, M.D.				23D. ADDRESS South Balto. Gen. Hosp. - 1213 Light St.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 13 65		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem Balto Md		24D. LOCATION (City, lawn, or county) (State) Curtis E. Evans					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR 1400 S Charles St Balto Md 21230		ADDRESS					

CURTIS E. EVANS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>B-625 65 7191</u>				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 7191</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Harry Henry Bergund</u>				2. DATE AND HOUR OF DEATH <u>July 7, 1965</u> <u>1:50</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland, #21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>26-09</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, #21224</u>				D. STREET ADDRESS (If rural, give location) <u>3911 Foster Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan-4-1883</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bethlehem Steel, Sparrows Pt.</u>			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Henry Bergund, dec.</u>			14. MOTHER'S MAIDEN NAME <u>? dec.</u>				
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-09-2447</u>				
17. INFORMANT <u>RECORDS: BCH, 4940 Eastern Ave., #21224</u>			ADDRESS				
18. <u>433.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> (A) DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u> (B) DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 21</u> 19 <u>65</u> to <u>July 7</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>July 7</u> , 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. Rathbun</u>				23B. DATE SIGNED <u>July 7, 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. RATHBUN</u>				23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Md., #21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/10/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Schwartz's</u>			
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 12 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Geo. Hoffmann</u>			
				ADDRESS <u>3218 Hudson St.</u>			

220

for 2

Bottomwater, 1/2 m. N.

Heavy, brown, etc.

2/10/1910

No. 1

1/10/1910

2/10/1910

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MILDRED SKINNER WILSON

2. DATE AND HOUR PRONOUNCED DEAD

10 July 1965

3:50 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10/25/1927

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John E Skinner

14. MOTHER'S MAIDEN NAME

Josephine Dudley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Edith Skinner 1915 Payson St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Gunshotwound of head

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

house

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

rear 1316 McCulloh St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

July 10, 1965 2:40 a.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/15/65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

NO. 1115

RECEIVED

1915

ALL COUNTY

WILLY FORGE

Clan

State of California

County of ...

42-77-89

FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

65 7193

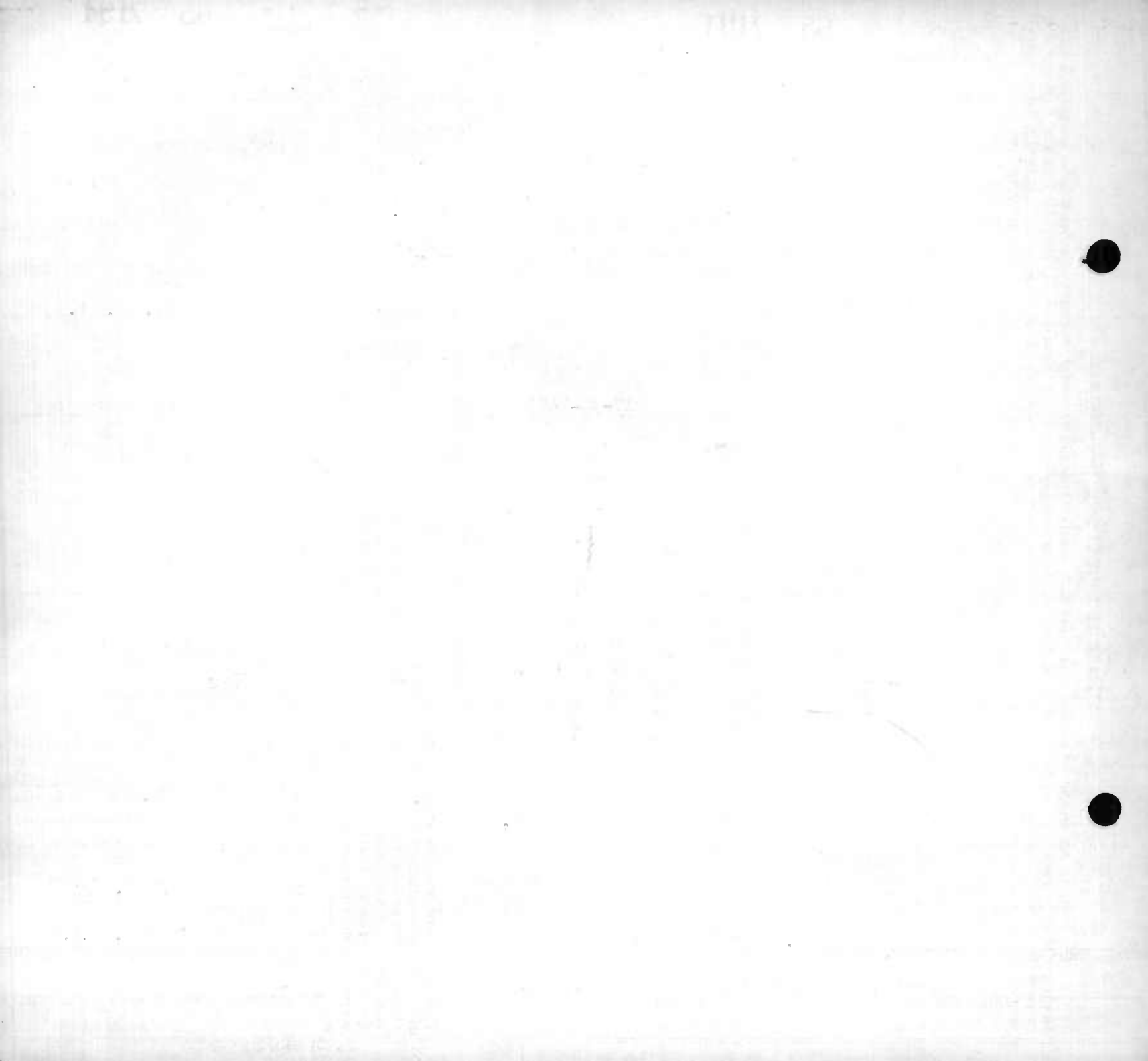
BIRTH NO. <u>1-520</u>		65 7193		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7193	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Allen Jones				July 7, 1965 10:45 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
31		Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		12-07	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		119 W. 22nd Street 21218	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	Negro	Single	12-25-1898	66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Virginia		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				RECORDS: BCM 4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) Pneumonia		24 Hours	
ANTECEDENT CAUSES				(B) Bronchogenic Carcinoma		5 Months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from February 4, 19 65 to July 7, 19 65, that (I) (we) last saw the deceased alive on July 7, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>H. Rathbun</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 7, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/10/65		Mt Calvary Cemetery		A A County Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 12 1965		Robert E. Faldut		A. Faldut		1206 W. North Ave	

LS: 43-93-98

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

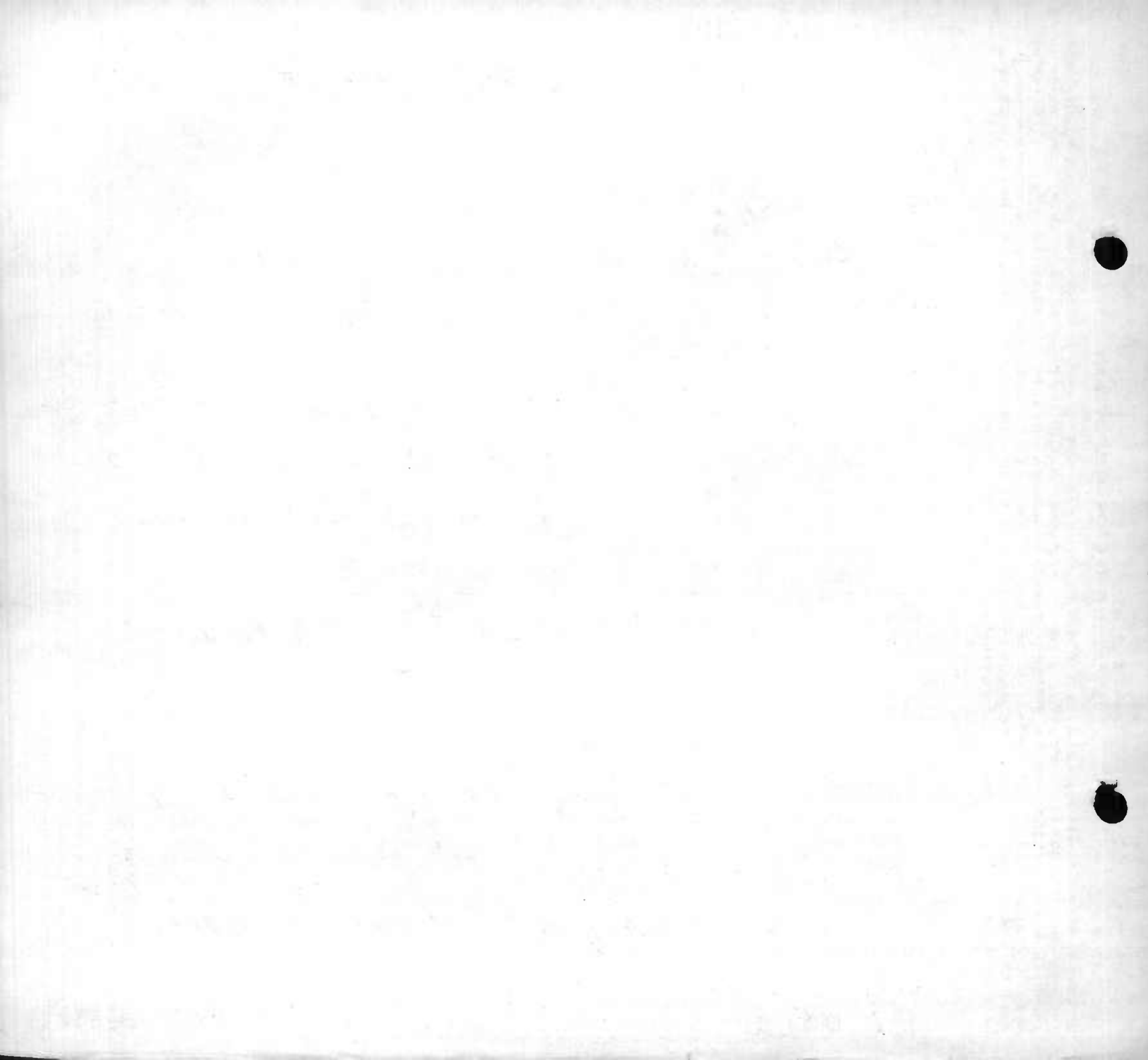
BIRTH NO. 65 7194		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7194	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Daniel Davis		July 7, 1965		3:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		Maryland		Baltimore	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		Negro		Never Married	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11-2-34		30		Laborer	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		U. S. A.			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
				217-30-7486	
17. INFORMANT		ADDRESS		RECORDS: BCH: 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		A. Massive Bleeding thru Tracheostomy			
ANTECEDENT CAUSES		B. Active Pulmonary Tuberculosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
7-2-65		Tracheostomy		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 22, 1965 to July 7, 1965, that (I) (we) last saw the deceased alive on July 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. Donald Baltzan				July 7, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Donald Baltzan		4940 Eastern Avenue Baltimore, Md. #24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/13/65		Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 12 1965		Robert E. Farley, M.D.		H. Halstead	
				1206 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7195	
BIRTH NO. 65 7195		CERTIFICATE OF DEATH		Registered No. 65 7195	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WRIGHT MR. ROBERT		2. DATE AND HOUR OF DEATH 7-9-65 15:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 12-04	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
BALTIMORE		411 E. 21 1/2 STREET			
6. SEX MALE	7. RACE NEGRO	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	9. DATE OF BIRTH 7-10-1900	10. AGE (In years last birthday) 64	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME STEVEN WRIGHT		14. MOTHER'S MAIDEN NAME LOUISE COSBY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-7750		17. INFORMANT PEARL HARRISON - 727 BARTLETT AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO CHF - Decompensated		2	
ANTECEDENT CAUSES		(B) DUE TO Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		malnutrition & dehydration			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-7-65 19 to 7-9 19 65 , that (I) (we) last saw the deceased alive on 7-9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruperto Manankil		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-9-65	
23C. PHYSICIAN'S NAME (Type) RUPERTO MANANKIL		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-13-65		24C. NAME of CEMETERY or CREMATORY MT. CALVARY	
24D. LOCATION (City, town, or county) BALTO. MD.		24E. STATE (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MARSHALL W. JONES, JR.	
ADDRESS 1735 HARFORD AVE.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7196		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7196	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) MARY CATHERINE MASON		2. DATE AND HOUR OF DEATH JULY 10 1965 17:15 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore County			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND 38 HOSPITAL, BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ROGERS FORGE 53-00			
		D. STREET ADDRESS (If rural, give location) 336 OLD TRAIL			
5. SEX F 80	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-8-84	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA-MARYLAND	
13. FATHER'S NAME CHARLES MULLER		14. MOTHER'S MAIDEN NAME Josephine Lentz		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 1215-05-7166		17. INFORMANT HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 420.1 9-260 X INTERVAL BETWEEN ONSET AND DEATH 12 hrs		CAUSE OF DEATH (A) Infarction of myocardium DUE TO (B) Atherosclerosis, coronary DUE TO (C) Diabetes mellitus		UNKNOWN UNKNOWN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE	
21D. TIME OF INJURY (APPROX.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NONE	
22. I certify that (we) (this hospital) attended the deceased from JULY 8 1965 to JULY 10 1965, that (I) (we) last saw the deceased alive on JULY 10 1965 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy Kenney Gray M.D.		23B. DATE SIGNED July 10, 1965		23C. PHYSICIAN'S NAME (Type) TIMOTHY KENNEY GRAY M.D.	
23D. ADDRESS 203 S. UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. J. Dickner + Sons Inc North & Penna. Bldg. 21217	

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD

SHELTON

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1965

3:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3020 W. North Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Feb. 17, 1910

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

Checker Cab Co.

11. BIRTHPLACE (State or foreign country)

Delaware

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

255-07-9331

17. INFORMANT

ADDRESS

Millie Darden-1801 Ellamont St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/13/65

23C. NAME of CEMETERY or CREMATORY

Mount Auburn

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 12 1965

Robert E. Farley, M.D.

Herbert E. Nutter 3035 W. North Ave

1871

1871

WALTER B. BEECH

WALTER B. BEECH

WALTER B. BEECH

43-87-13

FR

FUNERAL DIRECTOR: IMPORTANT

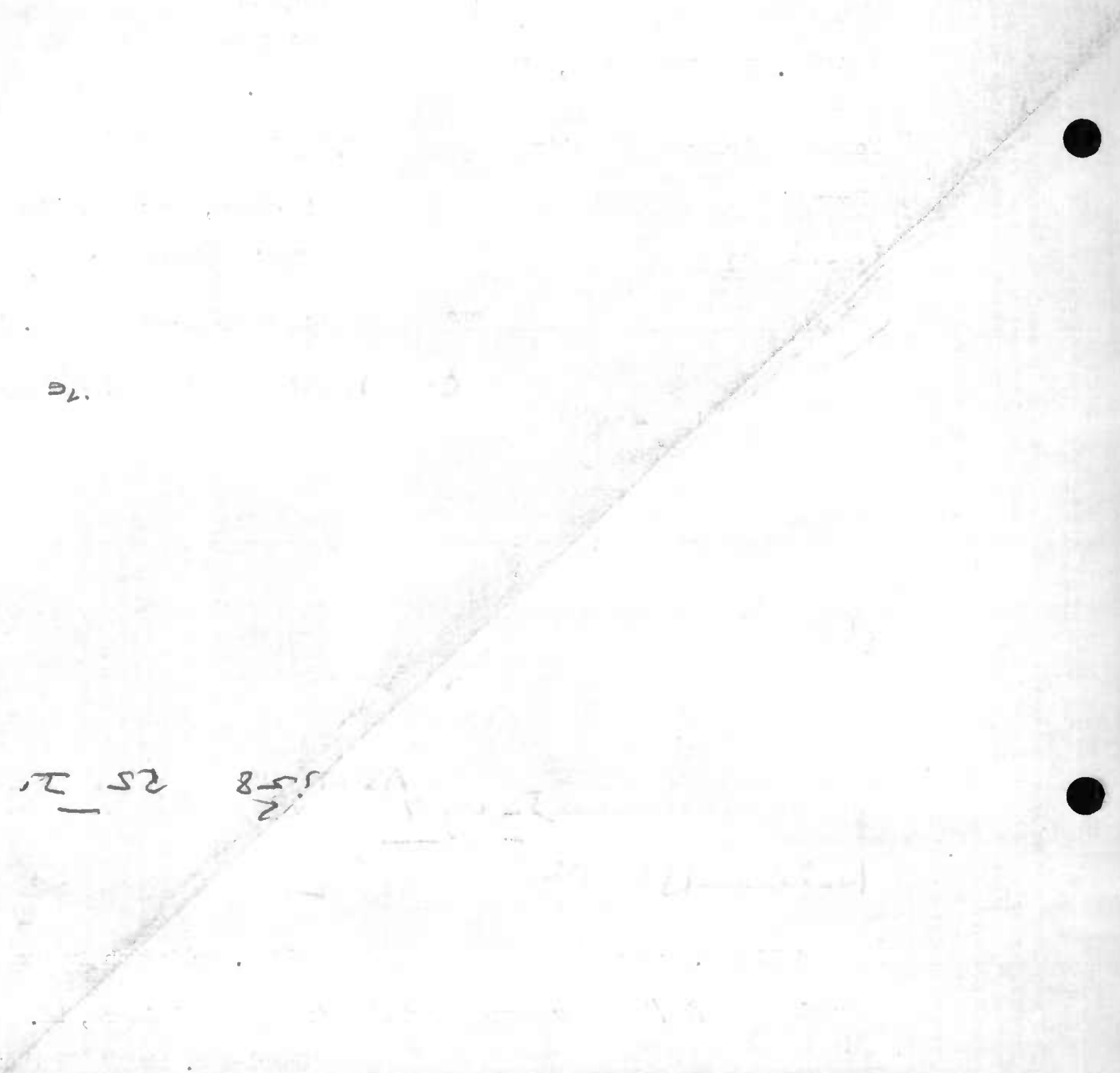
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7198				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7198	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William Holt				2. DATE AND HOUR OF DEATH July 7, 1965 5:55 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		15-04	
				D. STREET ADDRESS (If rural, give location) 2322 W. North Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-15-1875	9. AGE (In years last birthday) 89	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-30-9390		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue	
18. 609X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Right Lower Lobe Pneumonia DUE TO (B) Urinary Tract Infection DUE TO (C) Status Post Supra-pubic Cystostomy		INTERVAL BETWEEN ONSET AND DEATH 5 Days Many Months One Month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 14, 1965 to July 7, 1965, that (I) (we) lost saw the deceased alive on July 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. Rathbun				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stell. Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 7, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/65		24C. NAME of CEMETERY or CREMATORY Carver Mem Park		24D. LOCATION (City, town, or county) (State) Laurel Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Jarky, M.D.		25C. FUNERAL DIRECTOR Herbert E. Nutter		ADDRESS 3035 W. North Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				Registered No. 65 7199	
BIRTH NO. 65 7199		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Cora Smith		2. DATE AND HOUR OF DEATH July 9, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 649 N. Bentalou Street, 21222		A. STATE Maryland B. COUNTY 16-05			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 649 N. Bentalou Street			
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 5/19/1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winnshoro, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Bell		14. MOTHER'S MAIDEN NAME Minnie Nelson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wille Mae Brown ADDRESS 649 N. Bentalou Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular disease unknown		CAUSE OF DEATH DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 28 19 52 to July 9 19 65 , that (I) (we) last saw the deceased alive on July 7 19 65 and that (in my) four opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Watts		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-9-65	
23C. PHYSICIAN'S NAME (Type) William H. Watts		23D. ADDRESS 515 N. Arlington Avenue			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/12/65		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965			
25B. NAME OF REGISTRAR Robert E. Law		25C. FUNERAL DIRECTOR Charles R. Law ADDRESS 802 Madison Avenue			



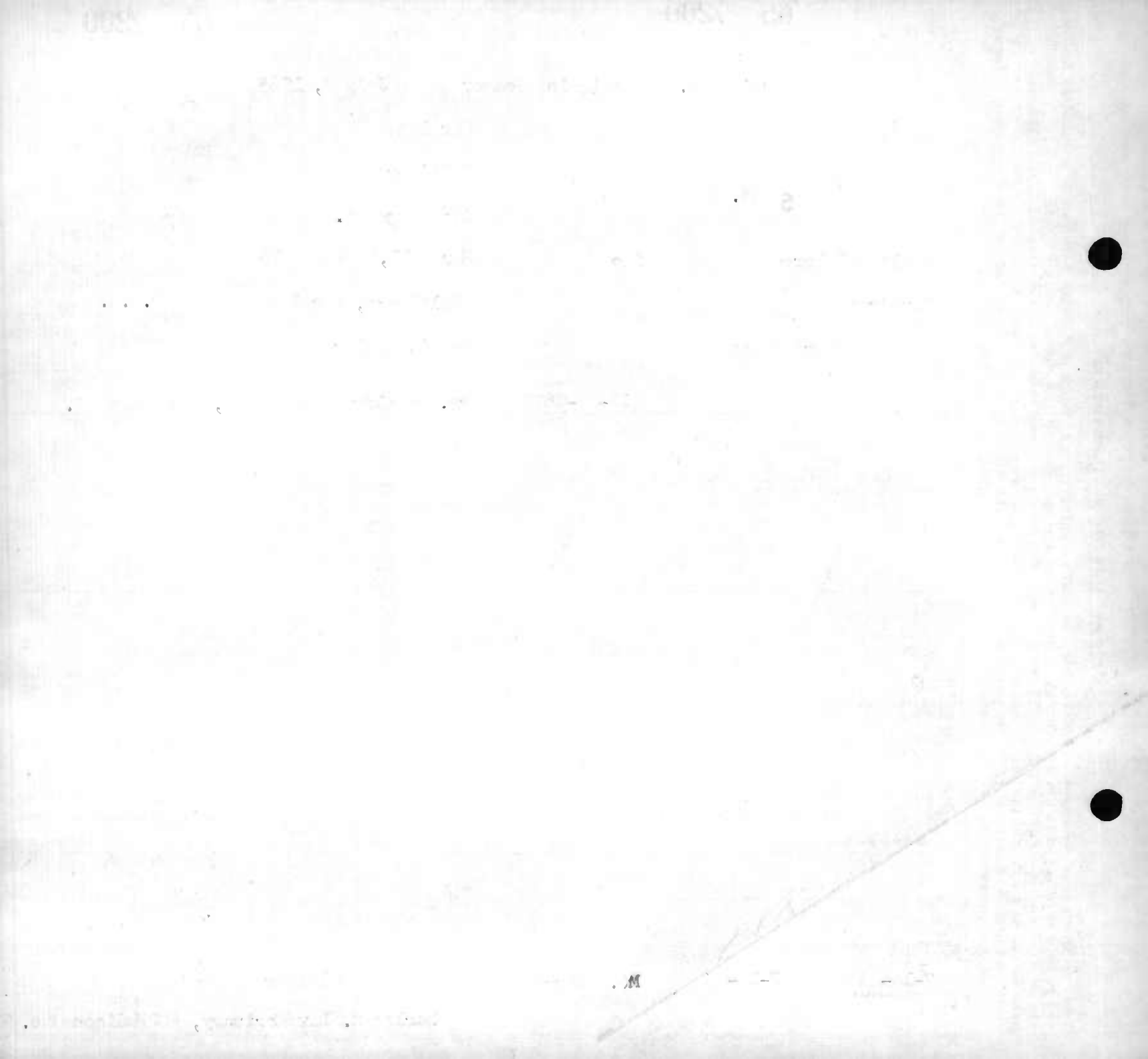
25-21 558

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 7200		CERTIFICATE OF DEATH		65 7200	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Harriett A. Payne (Pain) Seamer			July 9, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
00 476 Mance Ct.			Maryland 11-04		
5. SEX			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
Female			Baltimore		
6. RACE			D. STREET ADDRESS (If rural, give location)		
Colored			476 Mance St.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			E. DATE OF BIRTH		
Widow			March 21, 1889 76		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years last birthday)		
Laundress			76		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
			Baltimore, Maryland		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Edward Payne			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME		
No			Sophia Taylor		
16. SOCIAL SECURITY NO.			17. INFORMANT		
212-32-2673			Mrs. Etheldra Pennington, 476 Mance St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			Intersclerotic Heart Disease		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			??		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2/10/65 to 7/9/65, that (I) (we) last saw the deceased alive on 7/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Wm Seamer				7/12/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
William GARNER M.D.				1005 W 2nd of Fayette Ave Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7-14-65		Mt. Auburn	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 12 1965		Robert E. Farnham		Charles R. Law Mortuary, 802 Madison Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 7201					
BIRTH NO. 65 7201					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MRS CARRIE GARRETT					2. DATE AND HOUR OF DEATH 7/8/65 1 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Prosser Hospital					A. STATE M.D. B. COUNTY Balto					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00					
					D. STREET ADDRESS (If rural, give location) 5904 Old Frederick Road					
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/22/10	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Phillip Manigault					14. MOTHER'S MAIDEN NAME Dian M.N. Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-03-5055		17. INFORMANT Ernest Garrett		ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 155.1 I CARCINOMA OF GALLBLADDER WITH METASTASES					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH 2 years					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (t) (this hospital) attended the deceased from May 19 65 to July 19 65, that (l) (we) last saw the deceased alive on July 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (l) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Royston B. Scott M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 8, 65		
23C. PHYSICIAN'S NAME (Type) ROYSTON B. SCOTT M.D.						23D. ADDRESS 1801W Baltimore St				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/65		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Baltimore Md.			24D. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965			25B. NAME OF REGISTRAR Robert E. Taylor, MA			25C. FUNERAL DIRECTOR Wilmington S. Phillips			ADDRESS 1727 N. Monroe St.	

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 7202				
BIRTH NO. 65 7202		M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <i>Bertha Tustin</i>					2. DATE AND HOUR OF DEATH <i>July 10, 1965. 9:15 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1919 E. 30 th. St.</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9-06</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>1919 E. 30 th. St.</i>				
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>Jan. 17, 1890</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Albert R. Hayward</i>				14. MOTHER'S MAIDEN NAME <i>Mary L. Weaver</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Coronary Occlusion</i> DUE TO (B) <i>Hypertensive Arteriosclerotic Cardio-vascular Disease</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>Few Minutes</i> <i>3 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>June 19 63</i> to <i>July 19 65</i> , that (I) (we) last saw the deceased alive on <i>June 29 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Loy M. Zimmerman</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>7/12/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman</i> M.D.					23D. ADDRESS <i>3202 Harford Rd. Baltimore</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/14/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Rack Inc 5305 Harford Rd.</i>				

County of ...

Highway Department

No.

June 28 1912

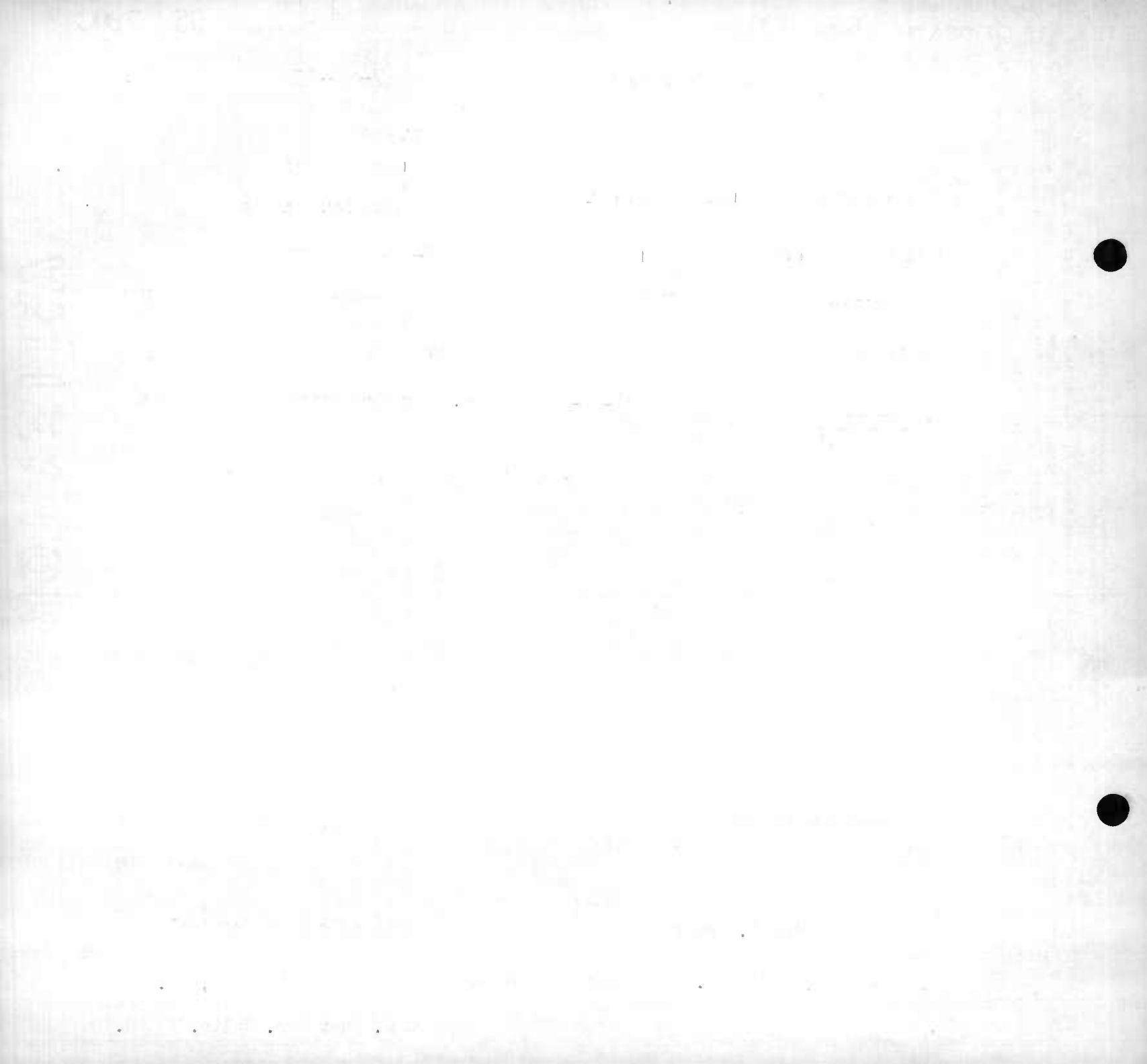
M. L. ...

3502 Harbor Rd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

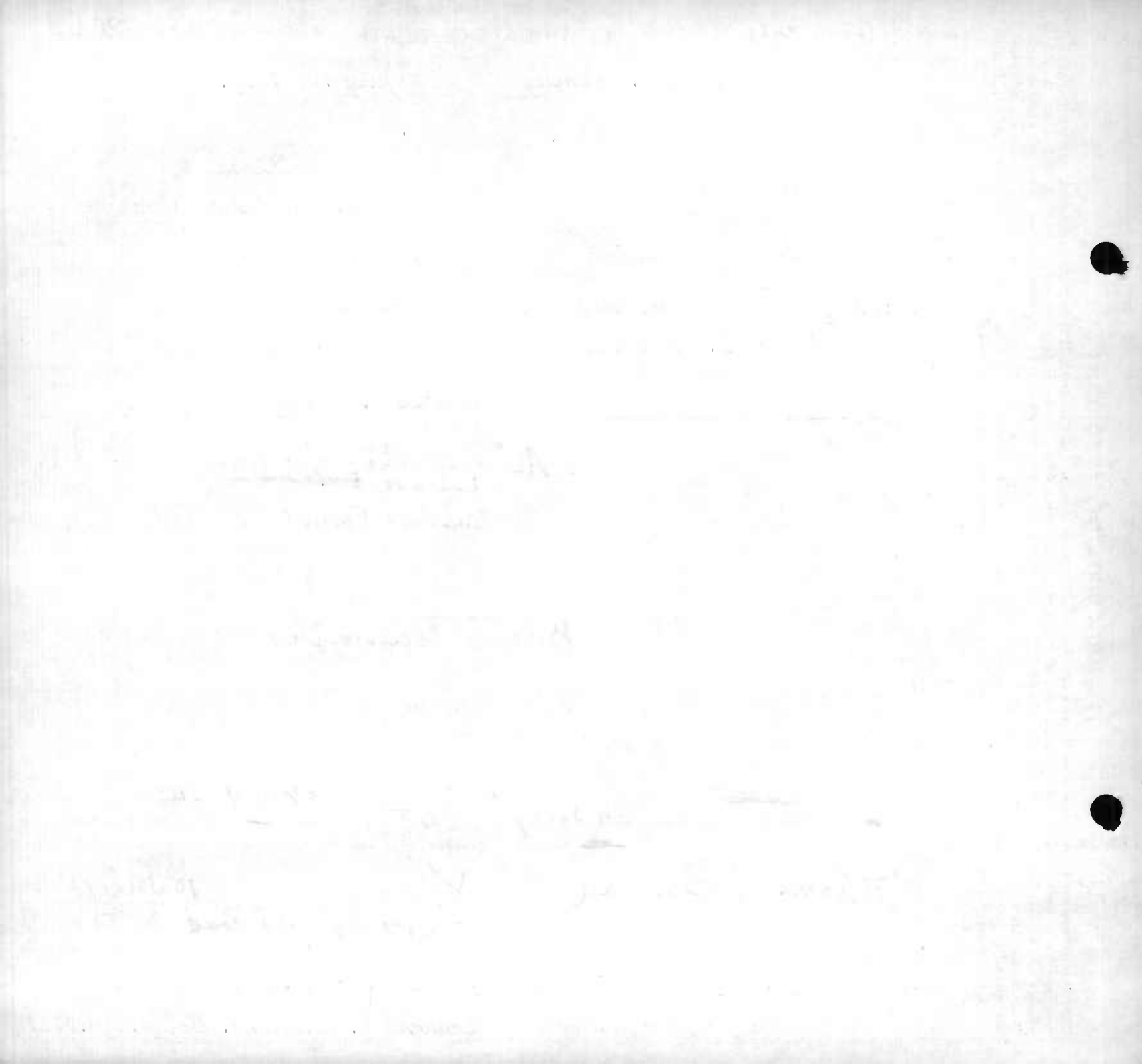
BIRTH NO. 65 7203				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7203	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HANS GUNDERSØN				2. DATE AND HOUR OF DEATH 7-10-65		6:55 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE #14 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #14 D. STREET ADDRESS (If rural, give location) 3203 JUNEAU PLACE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-21-84	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JUNERUS GUNDERSON				14. MOTHER'S MAIDEN NAME MESTA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-9980		17. INFORMANT Mrs. Emma Gundersen		ADDRESS (Same)	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Obstructive jaundice due to common duct stones. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obstructive jaundice due to common duct stones.				INTERVAL BETWEEN ONSET AND DEATH 3 days			
19A. DATE OF OPERATION 37-1-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OBSTRUCTIVE JAUNDICE		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 12 19 65 to JULY 10 19 65 , that (I) (we) last saw the deceased alive on JULY 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Brian D. Lowery M.D.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-65	
23C. PHYSICIAN'S NAME (Type) Brian D. Lowery		M.D.		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/16/65		24C. NAME of CEMETERY or CREMATORY Greenmount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

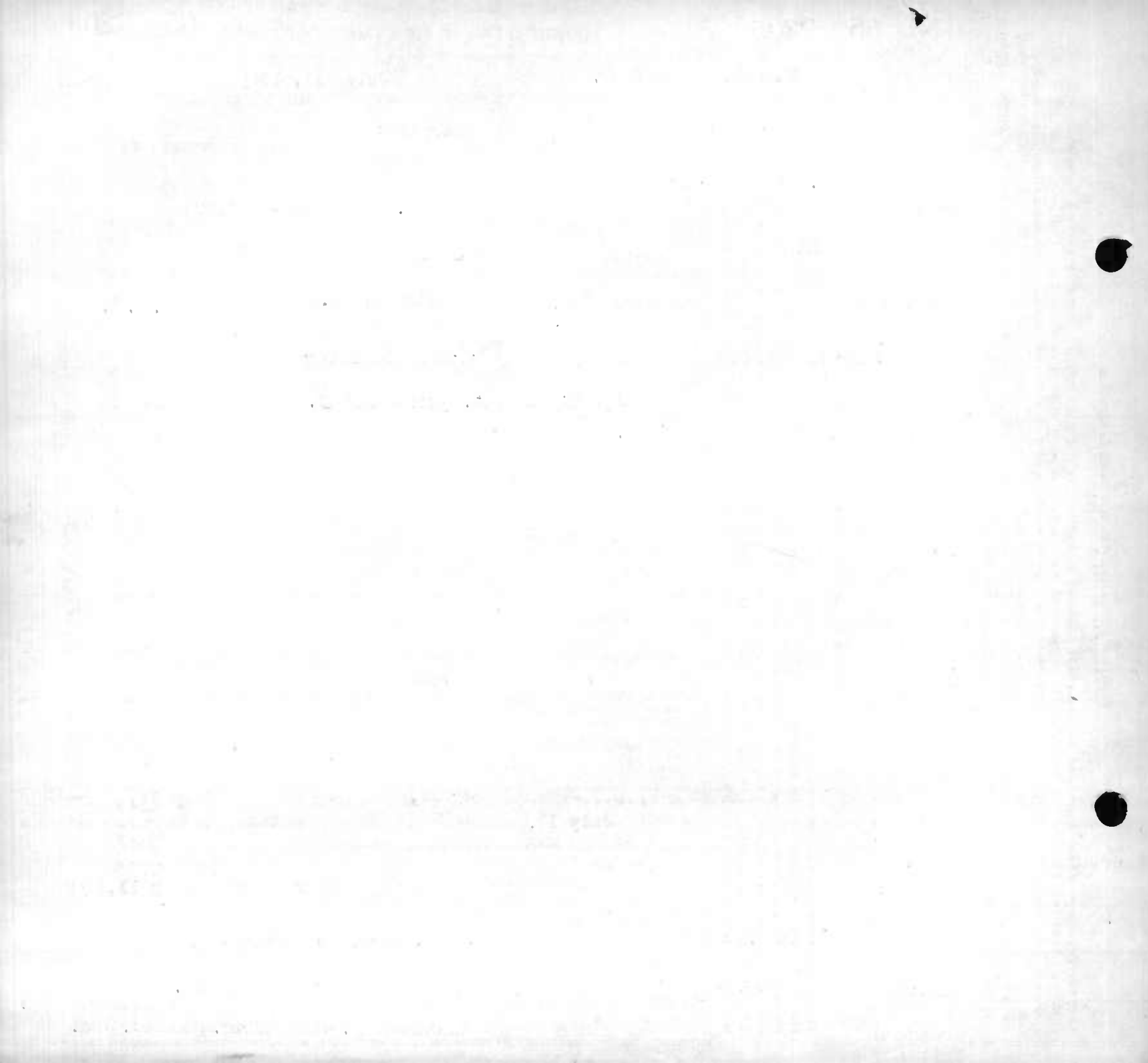
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 7204		CERTIFICATE OF DEATH		Registered No. 65 7204	
1. NAME OF DECEASED (Type or Print) <i>Cecelia M. Dohony</i>				2. DATE AND HOUR OF DEATH <i>July 10, 1965.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>Md.</i>		B. COUNTY			
<i>00</i>		<i>3815 Hamilton Avenue</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # 6</i>		D. STREET ADDRESS (If rural, give location) <i>3815 Hamilton Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>May 30, 1881</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Michael J. Creaghan</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Kelly</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Nicholas W. Dohony</i>		ADDRESS <i>(Same)</i>		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO (B) <i>Cardiac Failure</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>30 years</i> <i>1 week</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>Bilateral Pneumonia</i>			<i>3 days.</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>19 57</i> to <i>9 July</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9 July</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <i>Thomas J. Brennan</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>10 July 65</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>5217 Harford Road Balto 14 Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/13/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>R. E. Farley, MA</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i>		ADDRESS <i>21214</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

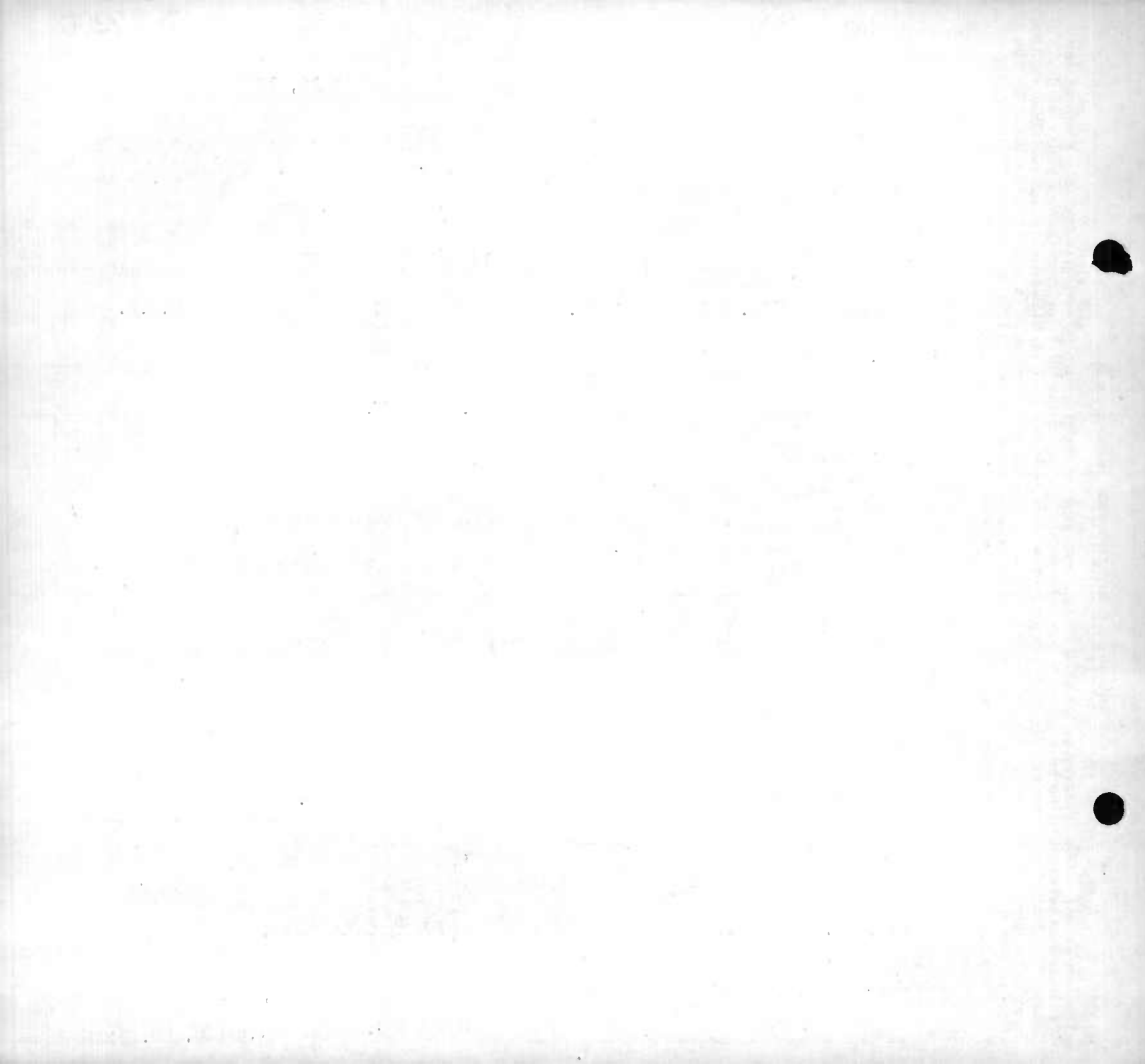
BIRTH NO. 2565 7205		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7205	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 65 7205	
1. NAME OF DECEASED (Type or Print)		ZIMMER, MARY R.		2. DATE AND HOUR OF DEATH July 11, 1965 6:05am M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 41 St. Joseph Hospital		Maryland 26-01		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 4412 Mary Avenue - 21206		5. SEX Female		6. RACE White	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 12-15-17		9. AGE (In years lost birthday) 47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Polley		14. MOTHER'S MAIDEN NAME Agnes Schultz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214010938		17. INFORMANT Mr. Guenther F. Zimmer	
18. CAUSE OF DEATH		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 12, 1965 to July 11, 1965 that (I) (we) last saw the deceased alive on July 11, 1965 and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Ramon P. Lopez		23B. DATE SIGNED July 11, 1965	
23C. PHYSICIAN'S NAME (Type) Ramon P. Lopez		23D. ADDRESS 1400 N. Caroline Street - 21213		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7/14/65		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

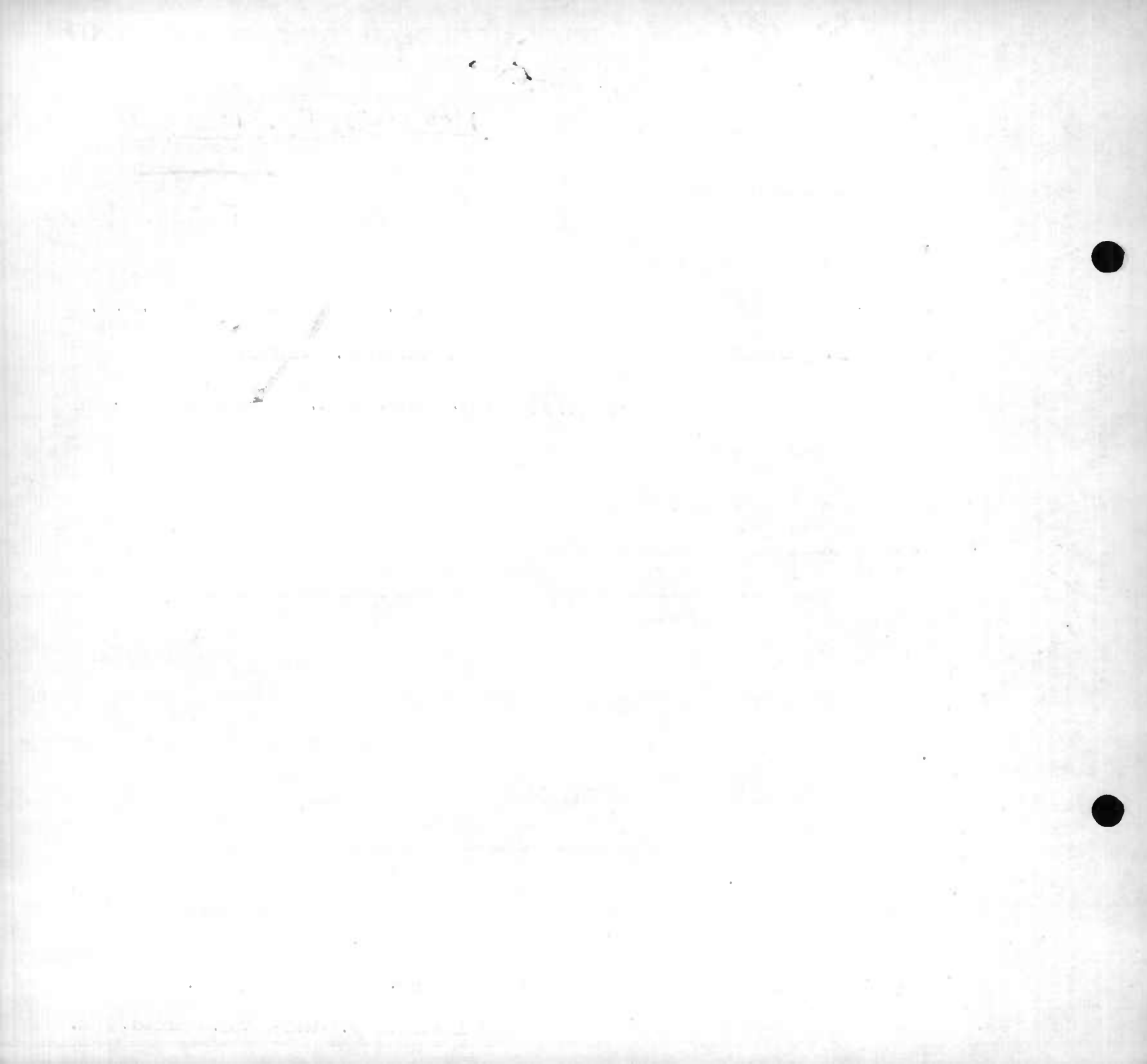
BIRTH NO. 65 7206				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7206	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALOYSIUS DEMEK				2. DATE AND HOUR OF DEATH JULY 10, 1965 10 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
6409 ROSEMONT AVENUE				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 6409 ROSEMONT AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/26/1893	9. AGE (In years lost birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRE FIGHTER BALTO. CITY FIRE DEPT.	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN W. DEMEK				14. MOTHER'S MAIDEN NAME MARGARET MECKEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. EDITH F. DEMEK		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Uremia				INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Chronic Pyelonephritis 10 years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Benign Prostatic Hypertrophy 20 years							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Paralysis Agitans		20A. AUTOPSY? (Yes or No) uncertain		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/9 to 7/10 19 65, that (I) (we) last saw the deceased alive on 7/9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Paul G. Mueller				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/10/65	
23C. PHYSICIAN'S NAME (Type) Paul G. Mueller				23D. ADDRESS 6411 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/65		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD.		ADDRESS 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

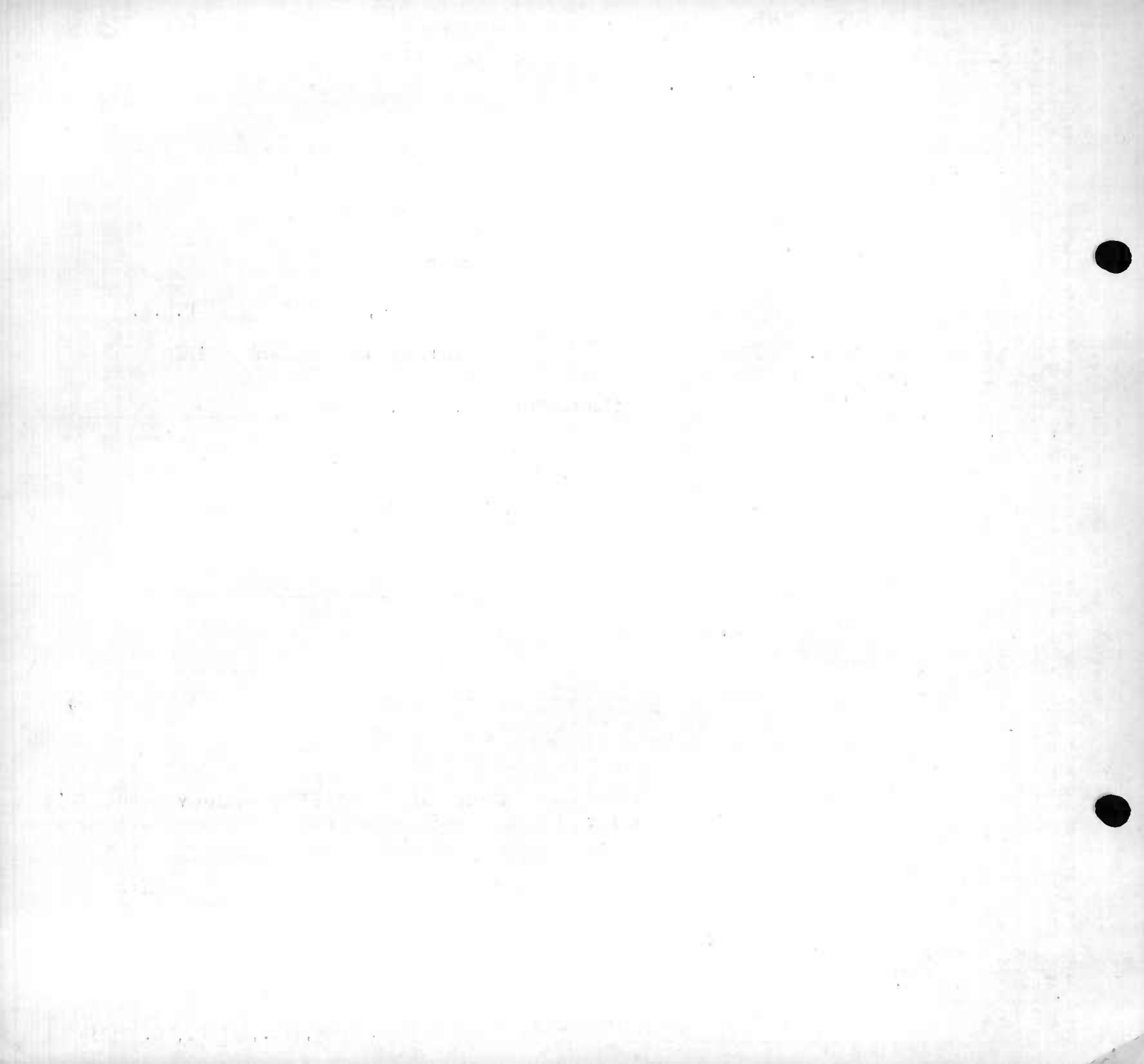
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7207	
BIRTH NO. 65 7207		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) McINTOSH, THELMA J.		2. DATE AND HOUR OF DEATH 7/9/65 3:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE & COUNTY MARYLAND BALTIMORE CITY B. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE HARTLAND 27-38 C. STREET ADDRESS (If rural, give location) 1450 CEDARCROFT RD 21212			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-28-03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harvey J. Gamber		14. MOTHER'S MAIDEN NAME Lillian S. Arnold	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217229779		17. INFORMANT Mr. William H. McIntosh	
18. 470.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Posterior Myocardial Infarction DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/9 1965 to 7/9 1965 that (I) (we) last saw the deceased alive on 7/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leon E. Kassel				23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/65		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965			
25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 7208	
BIRTH NO. 65 7208		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Kreis, Joseph A.				2. DATE AND HOUR OF DEATH July 9, 1965 4:05 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY 26-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4209 Sanner Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 07-30-85	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE J. KREIS				14. MOTHER'S MAIDEN NAME ELIZABETH (KASLAW) BAHLMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-05-3710		17. INFORMANT MRS. ELIZ. A BISCHOF		ADDRESS SAME
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) DUE TO Arteriosclerotic Cardiovascular (B) DUE TO Disease (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 30 1965 to JUL 9 1965, that (I) (we) lost saw the deceased alive on JULY 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Herman K. Gold M.D.				Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-9-65	
23C. PHYSICIAN'S NAME (Type) HERMAN K. GOLD				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/13/65		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214			



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65 7209

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7209

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Mary (MAY) L. ROSS

2. DATE AND HOUR PRONOUNCED DEAD

7/8/65 12:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3131 Orlando Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

May 24, 1907

9. AGE (in years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John McGraw

14. MOTHER'S MAIDEN NAME

Mary McGrath

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Miss Anna G. Brown

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and rheumatic heart
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Carcinoma of uterine cervix

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

3 7/8/65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

cancer of cervix

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

7-12-65

23C. NAME OF CEMETERY or CREMATORY

New Cathedral Cemetery Baltimore, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc Baltimore, Md.

ADDRESS

VALLEY HORSE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 7210		CERTIFICATE OF DEATH		Registered No. 65 7210	
1. NAME OF DECEASED (Type or Print) Beard Margaret NMN				2. DATE AND HOUR OF DEATH 8:25 a.m. July 9-65					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp. 33rd + Calvert street Baltimore, MD 21218				A. STATE Maryland B. COUNTY U.S.A					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
				D. STREET ADDRESS (If rural, give location) 4606 Arabia Avenue, Balto MD 21214					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 9/26/09		9. AGE (In years lost birthday) 65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, MD, U.S.A			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME John Malone				14. MOTHER'S MAIDEN NAME Mary Craig					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Guy S. Beard		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute fulminating ulcerative colitis				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Colitis				(B) DUE TO Dehydration, with fluid	
				(C) DUE TO and electrolyte imbalance, secondary of fluids					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diverticulosis									
19A. DATE OF OPERATION No June 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from July 1st 1965 to July 9th 1965 that (1) (we) last saw the deceased alive on July 9th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Kang Fan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 9-65			
23C. PHYSICIAN'S NAME (Type) KANG FAN				23D. ADDRESS Union Memorial Hosp. 33rd + Calvert st. Balto. MD 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/65		24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. 21214					

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FUNERAL DIRECTOR: IMPORTANT

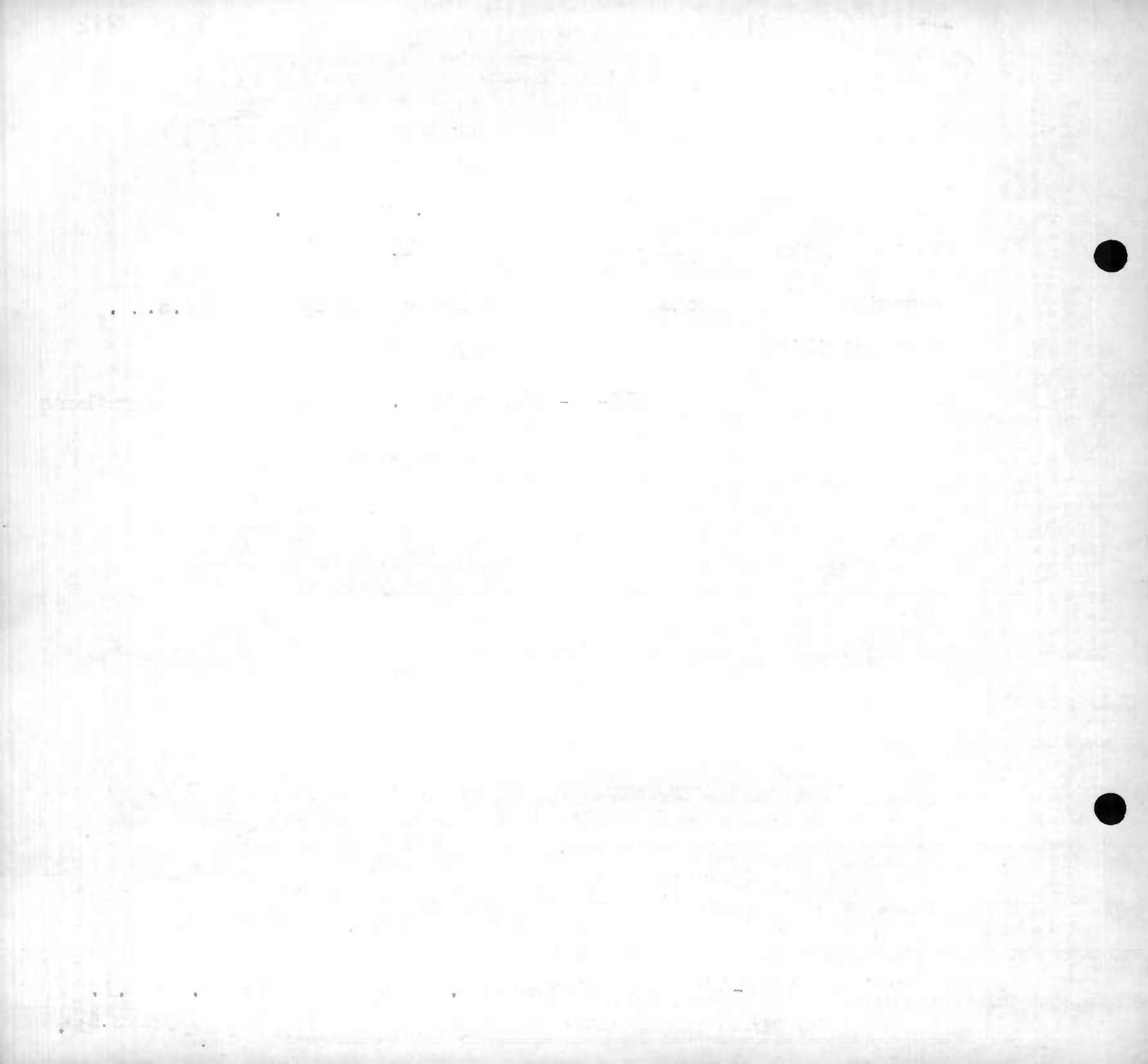
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. 65 7211		CERTIFICATE OF DEATH		Registered No. 65 7211	
1. NAME OF DECEASED (Type or Print) <i>Joseph L. Sauters</i>				2. DATE AND HOUR OF DEATH <i>July 10, 1965</i> <i>9 P M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33 John Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>53-00</i>			
				D. STREET ADDRESS (If rural, give location) <i>Box 719A Seneca Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		B. DATE OF BIRTH <i>May 18, 1873</i>	9. AGE (In years lost birthday) <i>92</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pattern Maker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Industrial</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herman H. Sauters</i>				14. MOTHER'S MAIDEN NAME <i>Emma Kirby</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>312073466</i>		17. INFORMANT <i>Mr. Edgar L. Sauters</i>		ADDRESS <i>Blvd 4200 Loch Raven</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Coronary occlusion</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
				(B) <i>ant. scl. coronary vasc. dis. many years</i> DUE TO			
				(C)			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>april 1962</i> to <i>July 9 1965</i> , that (I) (we) last saw the deceased alive on <i>July 9 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE <i>Louis Semenov</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7/10/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>LOUIS SEMENOFF</i>				23D. ADDRESS M.D. <i>2108 OREMS RD, BALTO 20, MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/13/65</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, MA</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., Balto., Md.</i>		ADDRESS <i>21214</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. Z 14065 7212		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7212	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Zappulla Mrs Gaetana		2. DATE AND HOUR OF DEATH 7-8-65 11:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		A. STATE Maryland B. COUNTY 3700			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 206 S. Exeter St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 5 1894	9. AGE (In years, months, days) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Palermo Italy	
13. FATHER'S NAME Santo Scibilia		14. MOTHER'S MAIDEN NAME Mary Nelita		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-4194		17. INFORMANT Santo A. Zappulla (Son)	
				ADDRESS 2007 Fern Glenway	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) pulmonary emboli		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 10 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO atrial fibrillation			
		(C) Arteriosclerotic heart disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/8/65 to 7/8/65 and that (I) (we) lost saw the deceased alive on 7/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. E. Kelly		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/8/65	
23C. PHYSICIAN'S NAME (Type) J. E. Kelly		23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Balt. Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank Della Noce	
				ADDRESS 322 S. High	



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D 120

65 7213

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 7213

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

7/8/65 15:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1029 Sarah Ann St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

May 19, 1892

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Sam Jackson

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Bertrude Jackson 1287 P. Amity St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/9/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 12, 1965

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Fairley

24C. FUNERAL DIRECTOR

Williams Funeral Home 3448 Schroeder St.

ADDRESS

WALLACE H. HOBBS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7214	
BIRTH NO. 65 7214		CERTIFICATE OF DEATH		Registered No. 65 7214	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY FORREST		2. DATE AND HOUR OF DEATH 7-9-65 11.45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) 2205 GUILFORD AVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 9-17-80	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) CHARLES CO. MD	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RICHARD BEVINS		14. MOTHER'S MAIDEN NAME MARTHA HEMSLEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DOROTHY FORREST 2205 GUILFORD ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Aspiration (B) Chr. colonic obstruction due to pt. c (C) Hypertensive cardiovasc. disease and diabetes mellitus.		INTERVAL BETWEEN ONSET AND DEATH Terminal variable - 1 wk years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II ? digitalis intoxication					
19A. DATE OF OPERATION 2 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR? -	
22. I certify that (this hospital) attended the deceased from 7/8/65 19 to 7/9 19 65, that (we) last saw the deceased alive on 7/9 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert I. Kermowitz M.D.		Attending Phys. [] Med. Director [] Staff Phys. [X]		23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type) Robert I. Kermowitz		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-13-65		24C. NAME OF CEMETERY or CREMATORY St JOSEPH'S	
24D. LOCATION Pomfret MD		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR ADDRESS Margaret P. Ryan 838 N. Gilman St	

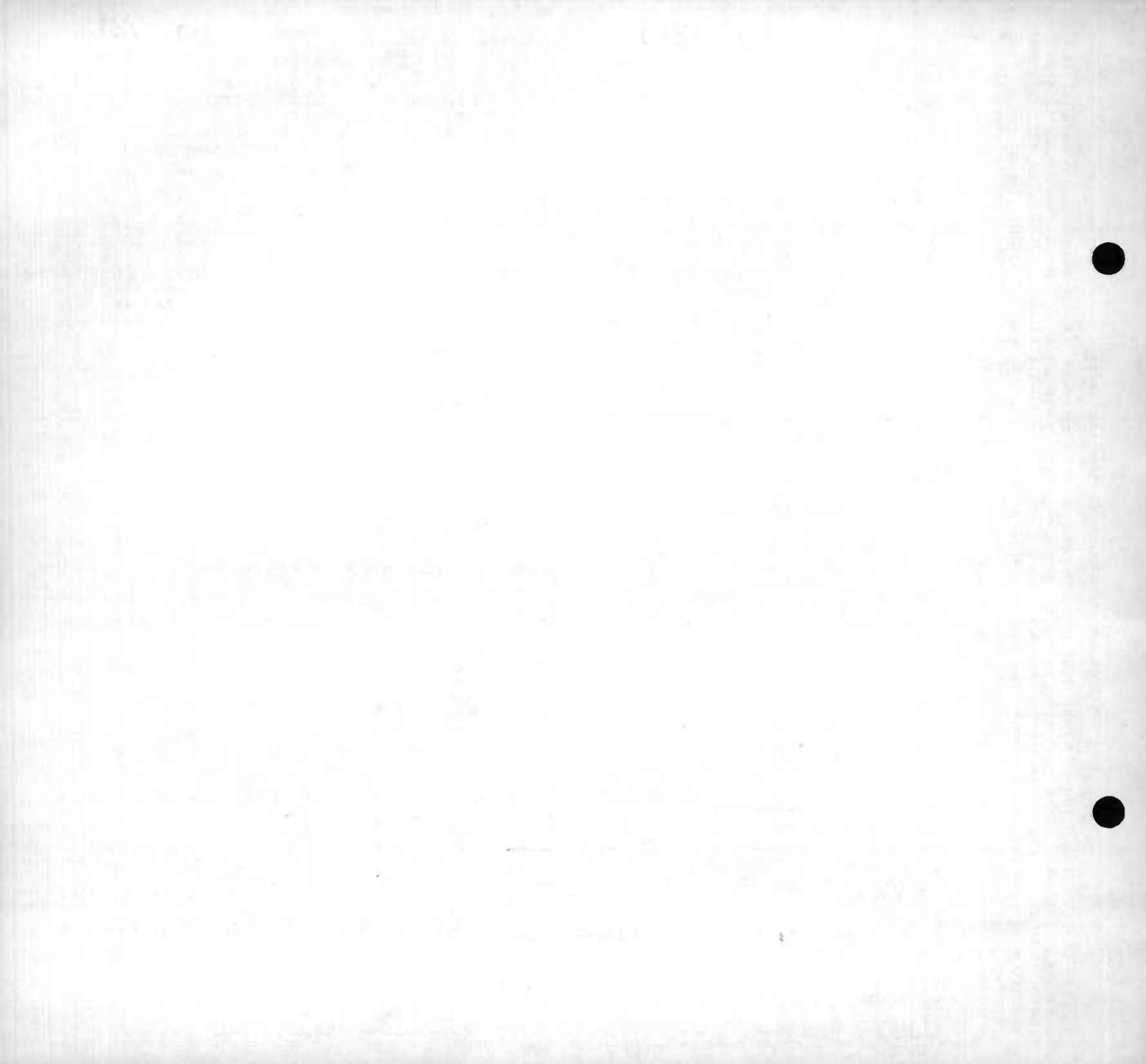
Handwritten notes, possibly a list or index, with some underlined text.

Handwritten notes at the bottom of the page, including a date "1875" and some illegible text.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

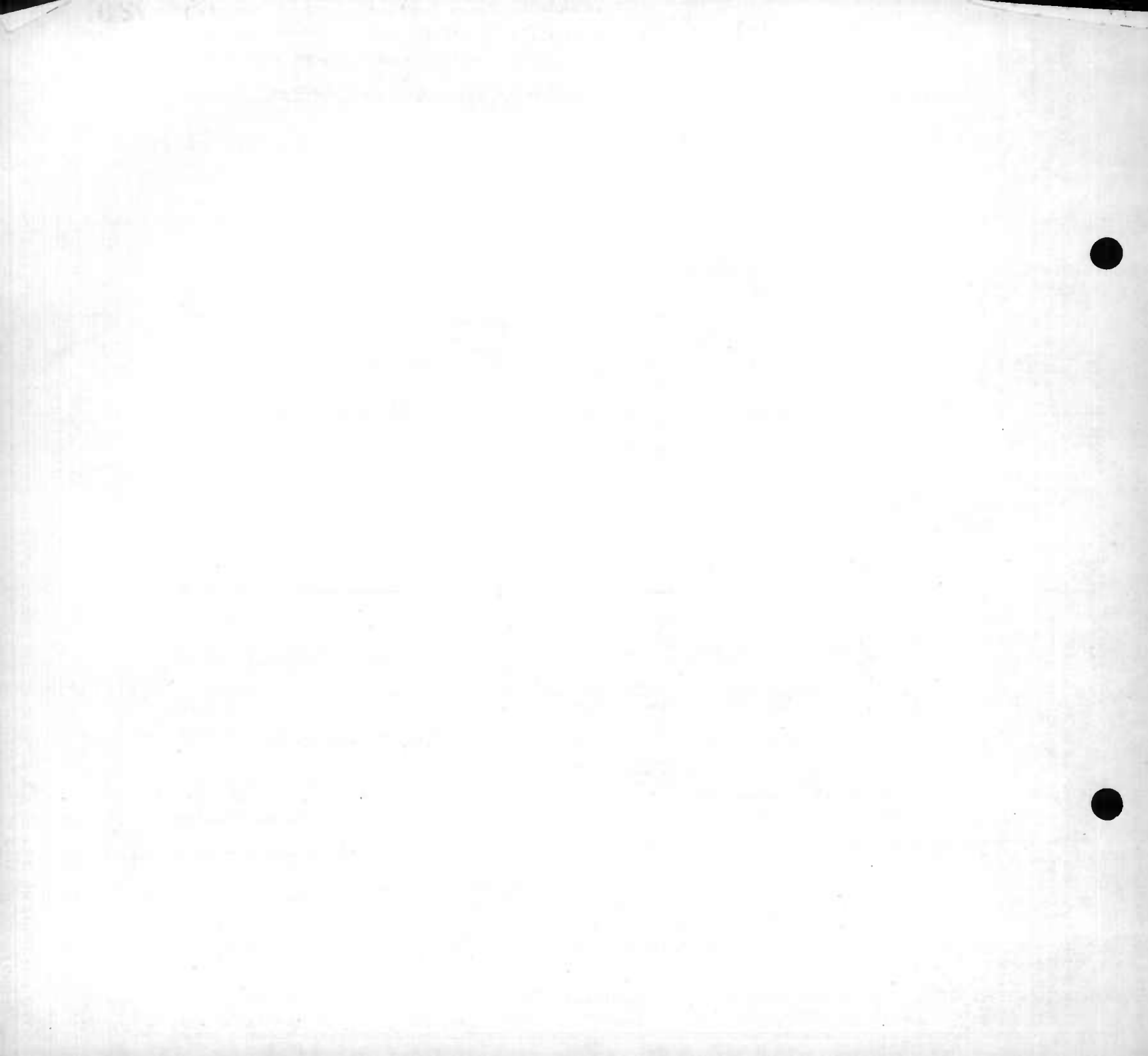
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65-7215	
BIRTH NO. 65-7215		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIE MAE SYKES			
2. DATE AND HOUR OF DEATH		JULY 9, 1965 3:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
UNIVERSITY HOSPITAL BALTIMORE, MARYLAND-21201		MARYLAND 17-03			
5. SEX F		6. RACE N		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Homemaker		ATHLETE		5/9/27	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 38	
JOHN BOATWRIGHT		MARIAN HILTON		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Fred Sykes 708 BRUNE ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) UREMIA DUE TO			
ANTECEDENT CAUSES		(B) ARTERIOLAR NEPHROSCLEROSIS DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ESSENTIAL HYPERTENSION			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from SEPT. 11 1958 to JULY 9 1965, that (I) (we) last saw the deceased alive on JULY 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
MARTIN C. SHARGEL M.D.				JULY 9, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MARTIN C. SHARGEL M.D.				UNIVERSITY HOSPITAL, BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Buried		7/14/65		BALTONATIONAL BALTIMORE	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 12 1965		R. E. FALKNER		Margaret P. Lingo 638 N. GILMAN ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

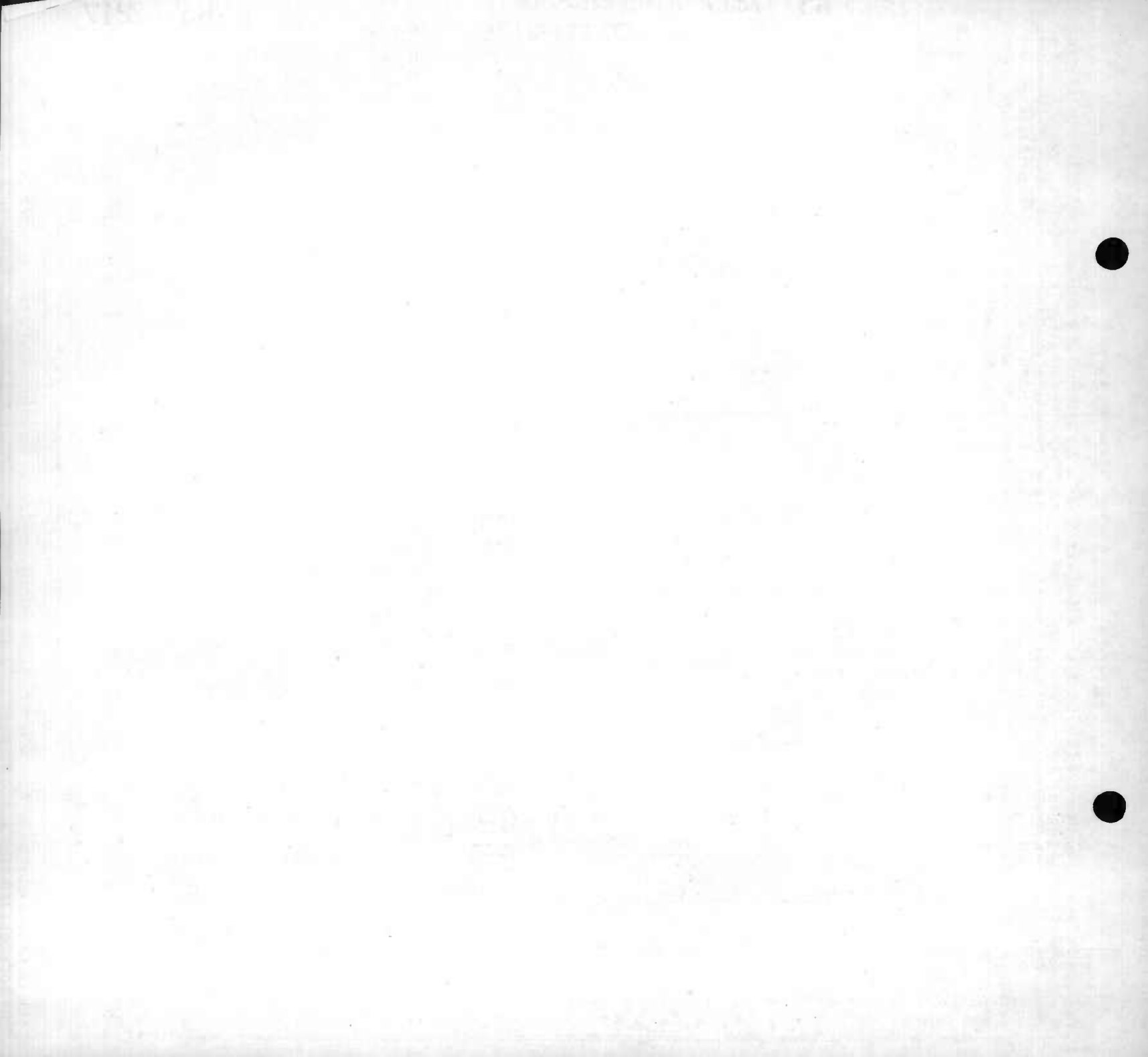
BALTIMORE CITY HEALTH DEPARTMENT				65 7216		65 7216	
BIRTH NO.				65 7216		Registered No.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
YANCEY, PAUL				8 July 65		9 ³⁰ A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
38 University Hosp				MD		2101	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE		21200	
				D. STREET ADDRESS (If rural, give location)			
				923 BURGUNDY ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
M	NEURO	MARRIED	1-29-05	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
LONGSHOREMAN		PORT OF BALTO		SUFFOLK - VA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN YANCEY				MARIA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		212-09-6103		JANIE YANCEY		9313 MYRTLE ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (if) (this hospital) attended the deceased from July 5, 19 65 to July 8, 19 65, that (if) (we) last saw the deceased alive on July 8, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Richard P. Norgaard M.D.				July 8 - 1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RICHARD P. NORGAAARD M.D.				University Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-12-65		Greenwood PR		Marshall MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 12 1965		Robert E. Fisher M.D.		Marshall & Wynn 638 N		Glenora ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7217	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 7217</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) SARAH HOLMES</p> </div> <div> <p>2. DATE AND HOUR OF DEATH July 6 - 1965 4:15 P. M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>2006 WALBROOK AVE</p>			<p>4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)</p> <p>A. STATE MD B. COUNTY 15-04</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 2006 WALBROOK AVE</p>		
<p>5. SEX Female</p>	<p>6. RACE Colored</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED</p>	<p>8. DATE OF BIRTH 7-19-1904</p>	<p>9. AGE (In years last birthday) 60</p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC</p>			<p>10B. KIND OF BUSINESS OR INDUSTRY PUT FAMILY</p>		<p>11. BIRTHPLACE (State or foreign country) SPARROWS PT. MD</p>
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>			<p>13. FATHER'S NAME JOSEPH HARRIS</p>		
<p>14. MOTHER'S MAIDEN NAME ELLEN HILL</p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		
<p>16. SOCIAL SECURITY NO. 219-10-9726</p>			<p>17. INFORMANT ADDRESS WM. HOLMES 2006 WALBROOK AVE</p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH</p> <p>(A) Metastatic carcinoma INTERVAL BETWEEN ONSET AND DEATH 4 months.</p> <p>(B) Carcinoma of colon 10+ mos.</p> <p>(C) _____</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
II					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION 01/11/1964</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction</p>		<p>20A. AUTOPSY? (Yes or No) No</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>(If in Baltimore City, give exact location)</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR?</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from Jan 1957 to 7-6 1965, that (I) (we) last saw the deceased alive on July 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Lucius W. Heeper</p>				<p>23B. DATE SIGNED 7-8-65</p>	
<p>23C. PHYSICIAN'S NAME (Type) Lucius W. Heeper M.D.</p>				<p>23D. ADDRESS 1200 Bloomingdale Rd</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 7-10-65</p>	<p>24C. NAME OF CEMETERY or CREMATORY Mt Calvary</p>	<p>24D. LOCATION (City, town, or county) (State) Brooklyn - Baltimore MD 25</p>		
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965</p>		<p>25B. NAME OF REGISTRAR R. E. Taylor M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Mansell P. Hays 638 N. Calver St</p>	



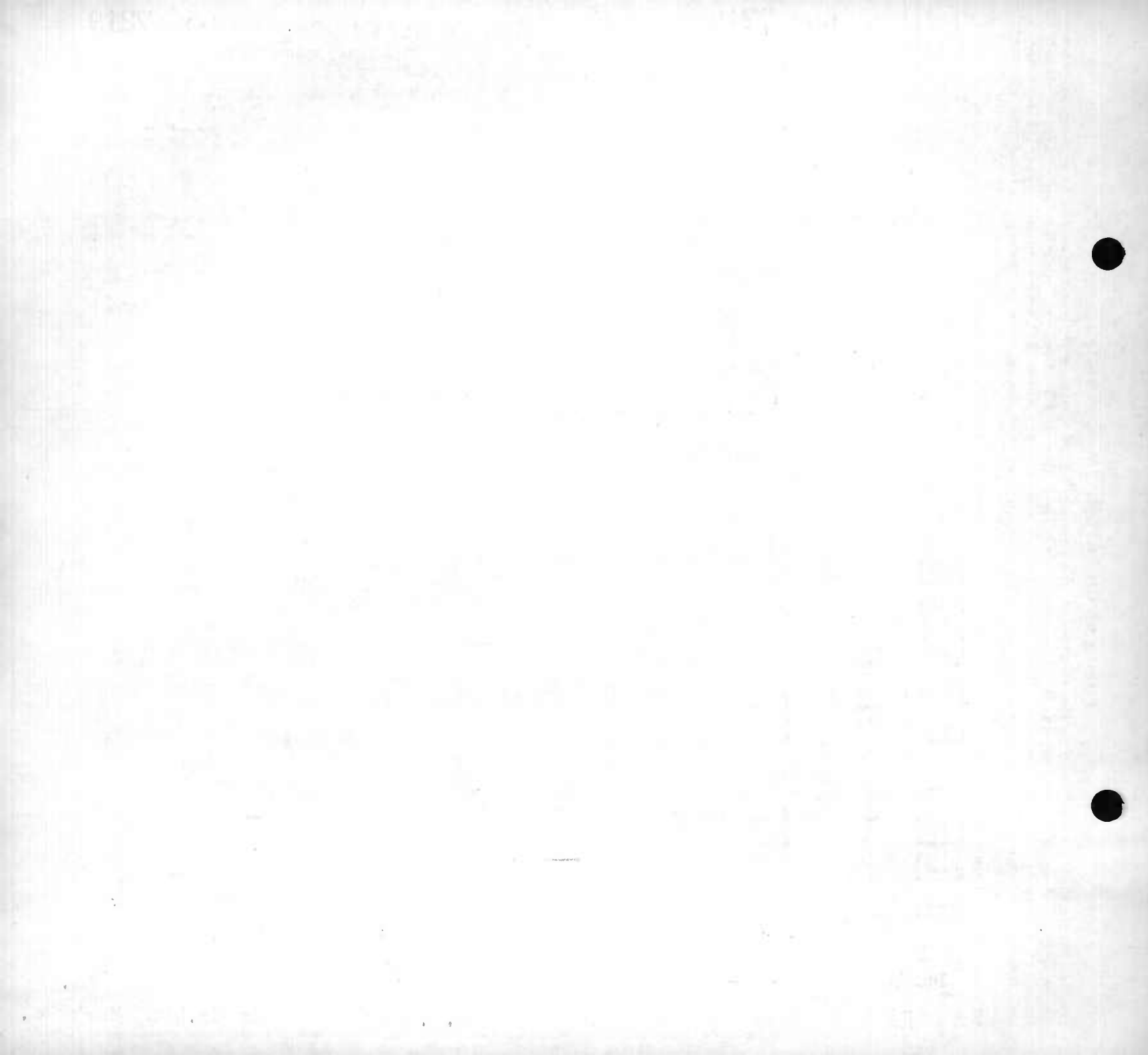
WALLLEY HOME

Clearing

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

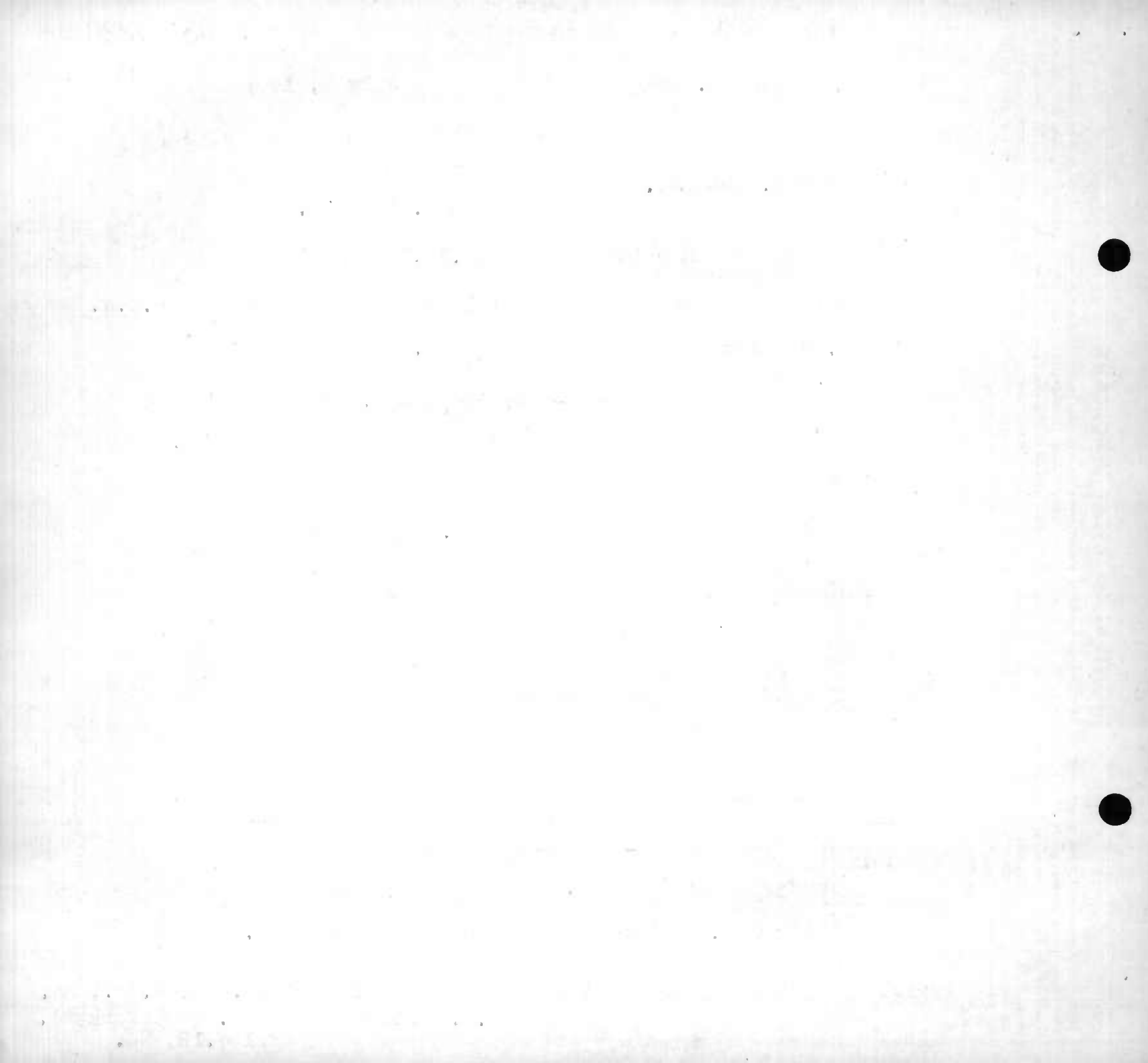
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 7219					CERTIFICATE OF DEATH					Registered No. 65 7219				
1. NAME OF DECEASED (Type or Print) HOWARD MORRIS JONES										2. DATE AND HOUR OF DEATH 7/9/65 5:55 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-48				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital 49										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
D. STREET ADDRESS (If rural, give location) 1238 Woodbourne Ave														
5. SEX M.		6. RACE W		7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify)) WIDOWED		8. DATE OF BIRTH 2/8/92		9. AGE (In years last birthday) 73		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Dept.					10B. KIND OF BUSINESS OR INDUSTRY Mo. Drydock					11. BIRTHPLACE (State or foreign country) New York				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME ROBERT T. JONES					14. MOTHER'S MAIDEN NAME MARY LUCAS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 214-03-2200					17. INFORMANT Patient's Chart				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction					CAUSE OF DEATH 20% Arteriosclerotic Cardiovascular disease, Acute					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO pulmonary edema					(C) DUE TO acute generalized peritonitis due to possible ruptured sigmoid diverticulum				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7/8 19 65 to 7/9 19 65 , that (I) was last saw the deceased alive on 7/9/1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.														
23A. SIGNATURE George Ruben										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				
23B. DATE SIGNED 7/9/65														
23C. PHYSICIAN'S NAME (Type) Dr. Seymour Ruben										23D. ADDRESS 3136 Harford Rd.				
24A. BURIAL CREMATION REMOVAL (Specify) Burial					24B. DATE 7-12-65					24C. NAME OF CEMETERY or CREMATORY Prospect Hill				
24D. LOCATION Towson					24E. LOCATION (City, town, or county) Md.									
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965					25B. NAME OF REGISTRAR Robert E. Farley					25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7220	
BIRTH NO. 65 7220		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Irene E. Krug		2. DATE AND HOUR OF DEATH July 9, 1965 4:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-01			
FULL NAME OF HOSPITAL OR INSTITUTION 620 E. 38th St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 620 E. 38th St.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 30, 1888	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wilmington, Delaware	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William H. Jackson		14. MOTHER'S MAIDEN NAME Emma I. Nothnagel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-28-8669		17. INFORMANT ADDRESS Stephen N. Krug (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 19 62 to July 9, 19 65, that (I) (we) last saw the deceased alive on July 8, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 9, 1965	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor		23D. ADDRESS 3902 Greenmount Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/1965		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Faldut	
25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					



FUNERAL DIRECTOR: IMPORTANT

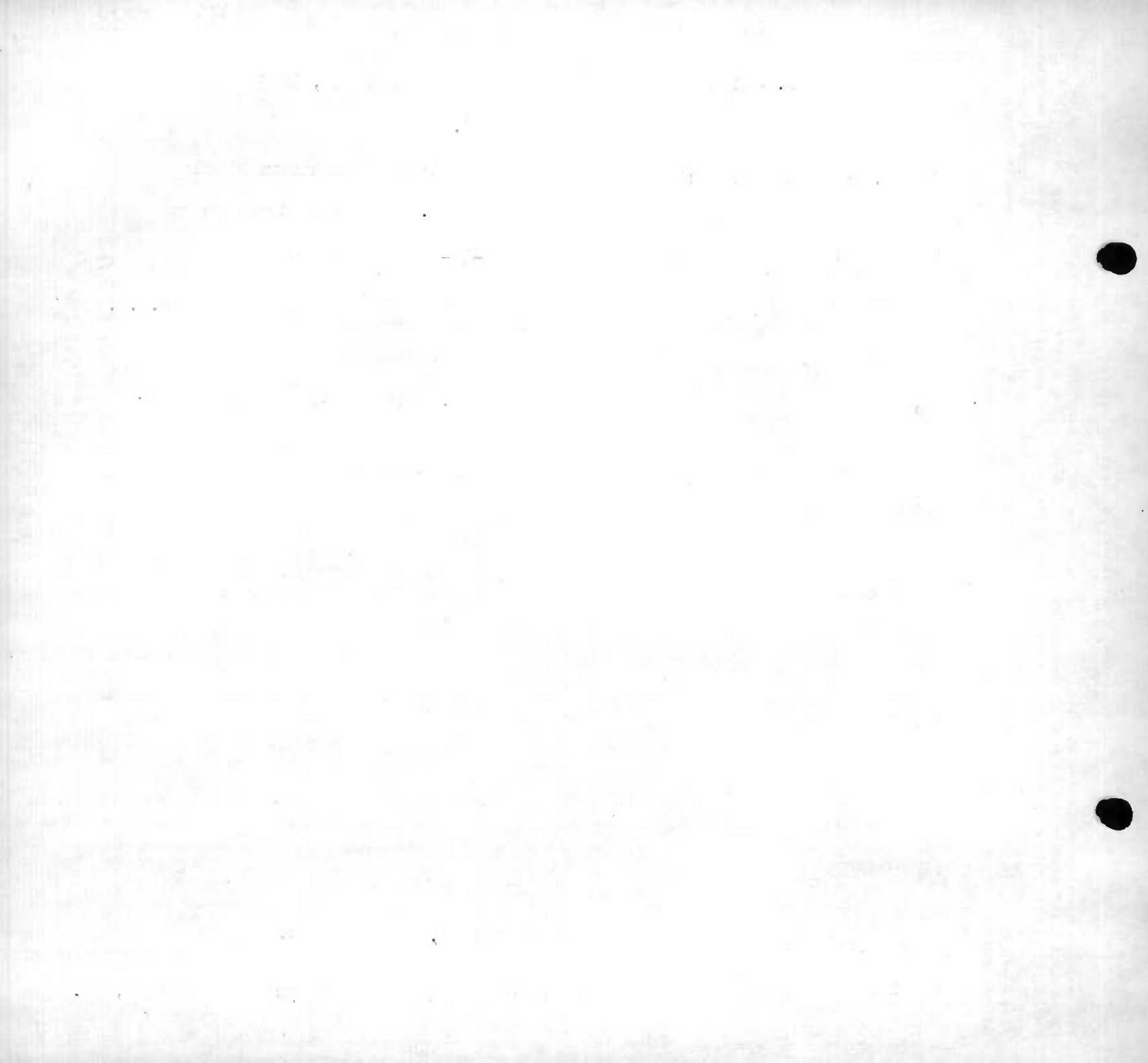
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7221		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7221	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ARRA CHANEY		2. DATE AND HOUR OF DEATH 7/9/65 4:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE Maryland		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			
		D. STREET ADDRESS (If rural, give location) 7333 YORKTOWN DR.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/10/92	9. AGE (In years lost birthday) 72 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY State Roads Comp		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Chaney		14. MOTHER'S MAIDEN NAME Sarah Hammond			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWI WWI		16. SOCIAL SECURITY NO. 220-36-8614A		17. INFORMANT HOSPITAL RECORDS MRS. NELLIE FOSTER CHANEY	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Acute pulmonary edema (B) Left ventricular failure (C) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3:15 AM 7/9/65 to 4:50 AM 7/9/65, that (we) lost saw the deceased alive on 4:50 AM 7/9/65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) view the body after death.					
23A. SIGNATURE Harry J. Brown		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type or Print) HARRY J. BROWN		23D. ADDRESS 2635 UNION MEMORIAL HOSPITAL BALT. MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-12-65		24C. NAME of CEMETERY or CREMATORY JESSOPS METHODIST CHURCH	
24D. LOCATION (City, town, or county) (State) SPARKS MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. JENKINS & SONS 4905 YORK RD 12	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7222				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7222	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Anna L. Quinn			
2. DATE AND HOUR OF DEATH July 10, 1965				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 139 S. Poppleton Street				A. STATE Md. B. COUNTY Baltimore 18-03			
5. SEX F				6. RACE W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed				8. DATE OF BIRTH 8-10-1880			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Farley				14. MOTHER'S MAIDEN NAME Anna Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Oria Knight				ADDRESS 5430 Montbel Ave #7			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Hemiplegia (B) DUE TO Hypertension (C) DUE TO Hypertension			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 4 1964 to Jan 4 1965, that (I) (we) lost saw the deceased alive on Jan 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles A. Cahn				23B. DATE SIGNED 7/12/65			
23C. PHYSICIAN'S NAME (Type) Charles A. Cahn				23D. ADDRESS M.D. 2145 W. Baltimore St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/13/65			
24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery				24D. LOCATION (City, town, or county) (State) Woodlawn Woodlawn, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965				25B. NAME OF REGISTRAR Robert E. Farley			
25C. FUNERAL DIRECTOR Wm. J. Pickner				ADDRESS north Pa. Balto 21217			



BIRTH NO. 65 7223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7223

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)HUGH MC TAGUE (Hugh Francis McTague)

2. DATE AND HOUR PRONOUNCED DEAD

9 July 196510:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Albion Hotel900 Cathedral St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

900 Cathedral St.

5. SEX

male

6. RACE

caucasian7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED
X Separated

8. DATE OF BIRTH

August 25, 1909

9. AGE (In years last birthday)

55

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk Retired

10B. KIND OF BUSINESS OR INDUSTRY

Lord Baltimore HotelBaltimore12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Patrick F. McTague

14. MOTHER'S MAIDEN NAME

Ellen Slattery

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YesWorld War 2

16. SOCIAL SECURITY NO.

216-03-3741

17. INFORMANT

ADDRESS

Mrs. Mary Stehli 931 St. Paul St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7/13/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 12 1965R. E. F. F.William J. Trickett & Son 112 N. Ave.

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WALLACE POLICE

ALL RIGHTS RESERVED

1/1/19

WALLACE POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7224	
BIRTH NO. 65 7224		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. Eva Taylor	
2. DATE AND HOUR OF DEATH 7-11-65 1:20 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			
A. STATE Md. B. COUNTY 27-15		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9			
D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave.		E. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Edwin Darrida		14. MOTHER'S MAIDEN NAME Eusebia Day	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-9012		17. INFORMANT Hospital Chart ADDRESS	
18. 341.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Peritonitis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) DUE TO		(B) DUE TO	
(C) DUE TO		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3-7-6-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Duodenal Ulcer		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-5-65 19 to 7-11-65 19, that (I) (we) last saw the deceased alive on 7-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nelson J. Hudson M.D.				23B. DATE SIGNED 7-11-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. Linden and Madison Aves.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemt.	
24D. LOCATION (City, town, or county) Pikesville Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm J. Dickerson			
25D. ADDRESS		25E. ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

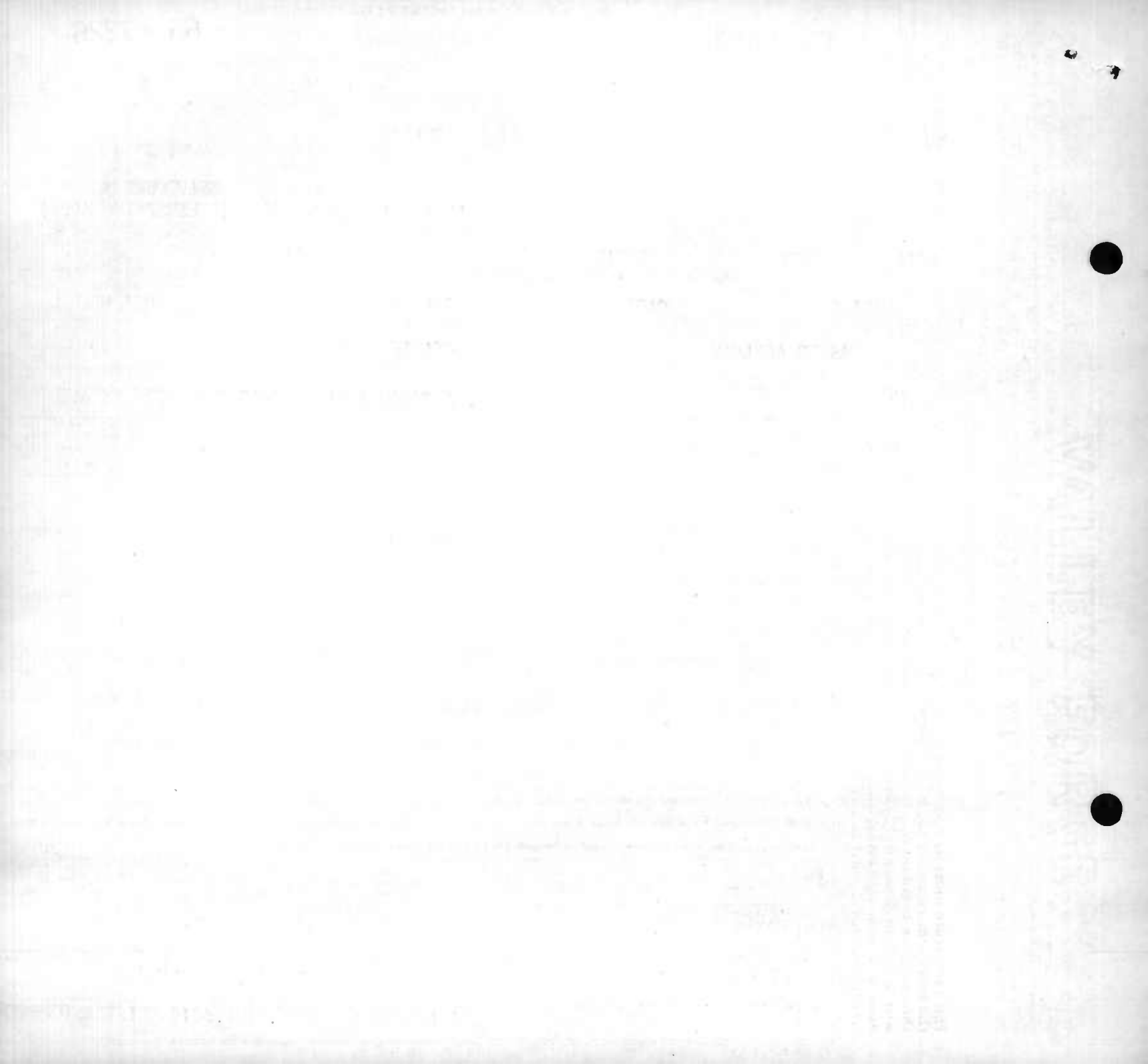
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7225	
BIRTH NO. 65 7225		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Charles Dooley</i>		2. DATE AND HOUR OF DEATH <i>7.11.65 10:35 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		A. STATE <i>Mo.</i> B. COUNTY <i>Balto</i>			
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Naval Yard</i>		8. DATE OF BIRTH <i>9-?-06</i>	
13. FATHER'S NAME <i>Laurence Dooley</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		9. AGE (In years last birthday) <i>63</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Accident Room Chart</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>422.11</i>		CAUSE OF DEATH <i>CUA</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>ASCVD</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Malnutrition & Dehydration</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>7.10.65</i> to <i>7.11.65</i> that (1) (we) last saw the deceased alive on <i>7.11.65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7.11.65</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. <i>Linden and Madison Sts.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>7/15/65</i>		24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemt.</i>	
24D. LOCATION (City, town, or county) (State) <i>Philadelphia, Pa.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 12 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Wm. Lickner Sons</i>	
				ADDRESS <i>North Blue Bell Rd</i>	

[Signature]

FUNERAL DIRECTOR: IMPORTANT

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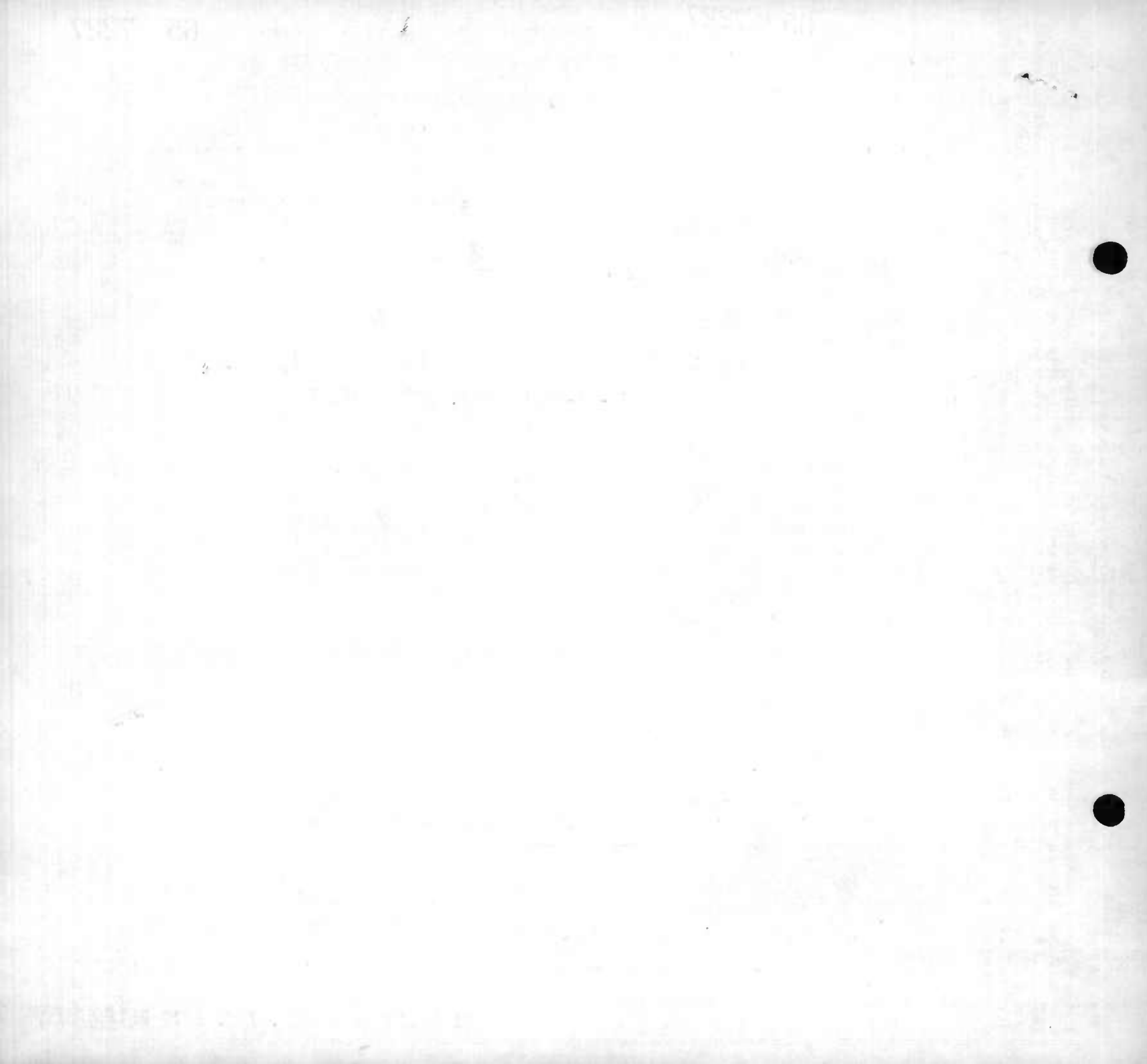
BIRTH NO. 65 7226				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7226	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ADELMAN SOL				2. DATE AND HOUR OF DEATH July 6, 1965 8¹⁵ p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVINDALE, HEBREW HOME AND INFIRMARY.				A. STATE MARYLAND B. COUNTY BALTIMORE			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) BEVEDERE & LEVINDALE HEBREW HOME (GREENSPRING AVES)			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH	9. AGE (In years last birthday) 66	(If Under 1 Yr. Months Days) (If Under 24 Hrs. Hours Min.)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAKING		10B. KIND OF BUSINESS OR INDUSTRY CAPS		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ASHER ADELMAN				14. MOTHER'S MAIDEN NAME GOLDIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. ABRAHAM ADELMAN 4827 PARK HEIGHTS AVE			
18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 8-22-1958 to 7-6-1965 , that (H) (we) last saw the deceased alive on 7-6-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Willner				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-6-65	
23C. PHYSICIAN'S NAME (Type) RUTH WILLNER				23D. ADDRESS LEVINDALE, HEBREW HOME & INFIRMARY			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/65		24C. NAME OF CEMETERY or CREMATORY RUDOMER VEREIN		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 65 7227
BIRTH NO. 65 7227										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) Herman M Neistadt					2. DATE AND HOUR OF DEATH 7-6-65 2:42 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hosp. Inc.					A. STATE MARYLAND					
					B. COUNTY 15-38					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 3405 FOREST PARK AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N M		8. DATE OF BIRTH 9-3-10	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED ELECTRICAL APPLIANCES				10B. KIND OF BUSINESS OR INDUSTRY MD.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JACOB NEISTADT				14. MOTHER'S MAIDEN NAME SOPHIA MAZOR						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 212-01-0241		17. INFORMANT ADDRESS MRS. SOPHIE NEISTADT 3405 FOREST PARK AVE				
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Hypertensive Crisis DUE TO (B) Hypertension DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH Approx 2 hrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 7-6 19 65 to 7-6 19 65 , that (I) (we) last saw the deceased alive on 7-6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
23A. SIGNATURE Werner Beck					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7-6-65		
23C. PHYSICIAN'S NAME (Type) Werner Beck					23D. ADDRESS Mercy Hosp., Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 7/7/65		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965			25B. NAME OF REGISTRAR Robert E. Fairbank			25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN R				



BIRTH NO. 65 7228

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)SEAN *Arnold* FARRER

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1965

11:10 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1203 N. Ensor Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)*Single*

8. DATE OF BIRTH

*7-4-65*9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

5

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)*Single*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ruben Farrer

14. MOTHER'S MAIDEN NAME

*Cynthia Walker Johnson*15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Eleanora Danahy

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Congenital Heart Disease (Fibro-
~~elastosis~~ elastosis).ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)*Burial*

23B. DATE

7-10-65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem Balto

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Rayner Sanders 217 E Preston

ADDRESS

8851 9

1000

WILLIAMSON

APR 27 1941

Charles

65 7229
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

65 7229
Registered No.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

IDUS

WIMBERLY

2. DATE AND HOUR PRONOUNCED DEAD

July 8, 1965

12:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Linthicum Heights

D. STREET ADDRESS (If rural, give location)

Box 855, Elkridge Landing Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Nov 3 - 1896

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Garden Ga.

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

Solman Wimberly

14. MOTHER'S MAIDEN NAME

Lottie Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

17. INFORMANT

Myrtle Wimberly

ADDRESS

Linn

18.

E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Generalized Peritonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Gunshot Wounds of Abdomen.
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Elkridge Landing Road, Linthicum Hgts.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 5 '65 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during altercation.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-12-1965

23C. NAME of CEMETERY or CREMATORY

Baltimore Natl Cem

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 12 1965

24B. NAME OF REGISTRAR

Robert E. Fadden, M.D.

24C. FUNERAL DIRECTOR

Choy Wilson - 1000 Brantley Ave.

ADDRESS

WALTER DOBBS

James P. ...

James P. ...

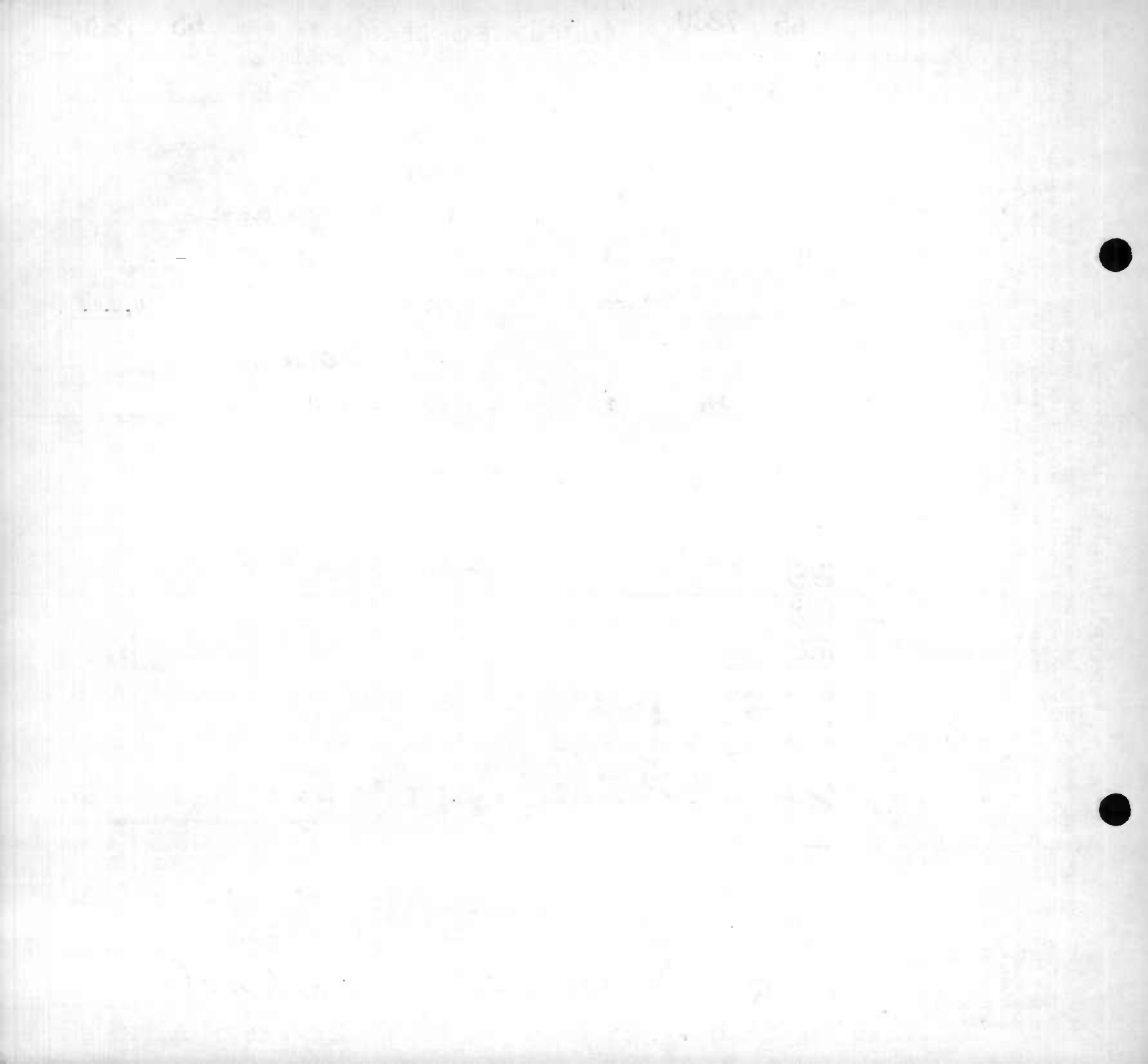
James P. ...

James P. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

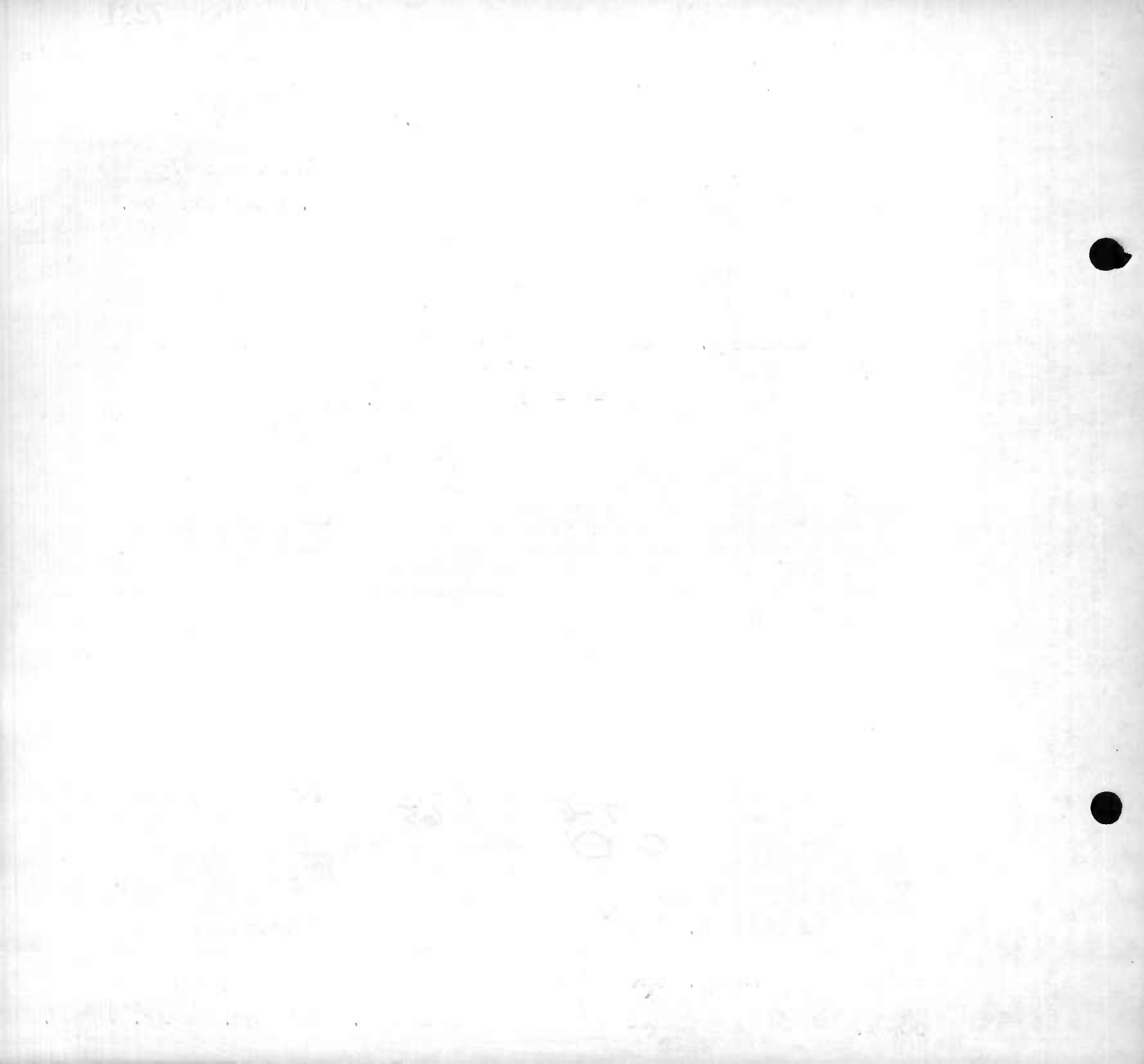
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 7230	
BIRTH NO. 65 7230							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) ROBINSON, ERNEST				2. DATE AND HOUR OF DEATH 7 July 65 8²⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		(If not in hospital or institution, give street address or location)		A. STATE Baltimore		B. COUNTY 21223#	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Maryland		19-02	
				D. STREET ADDRESS (If rural, give location) 1708 W. St Fayette Street			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 7/7/33	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Robinson				14. MOTHER'S MAIDEN NAME Rose Monday			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? ? No		16. SOCIAL SECURITY NO. C		17. INFORMANT Patient's Chart		ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Atherosclerotic cardio-vascular DUE TO (C) dissect		INTERVAL BETWEEN ONSET AND DEATH ~ 12 hrs years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 7 July 19 63 to 7 July 19 65 , that (H) (we) last saw the deceased alive on 7 July 65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard P. Norgaard				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7 July 65	
23C. PHYSICIAN'S NAME (Type) Richard P. Norgaard RICHARD P. NORGAARD				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-1965		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Choy Wilson		ADDRESS 1003 Brantley Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 7231		BALTIMORE CITY HEALTH DEPARTMENT		65 7231	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BATLAS, S. GEORGE		7-6-65 7:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hosp. of Balto. Inc Belvedere and		A. STATE Md. B. COUNTY		27-18	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore #15	
		D. STREET ADDRESS (If rural, give location)		4022 W. Garrison Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
M	Caucasian	Widowed	5-10-02	63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Retired Chef			Greece	USA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Stephen G. Batlas			Clara ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
		220-20-5316	Stephen C. Batlas		(Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Acute Myocardial Infarction		4 and 1/2 hrs	
		(B) DUE TO Atherosclerotic Cardiovascular Disease			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-6-65 19 65 to 7-6-65 19 65, that (I) (we) last saw the deceased alive on 7-6-65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Stanley L. Blum				7-6-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Stanley L. Blum		Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	7/10/65	Long View Cemetery	New Athens, Ohio		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS		
JUL 12 1965	Robert E. Farley, M.D.		Leonard J. Ruck Inc. Balto. 14 Md.		

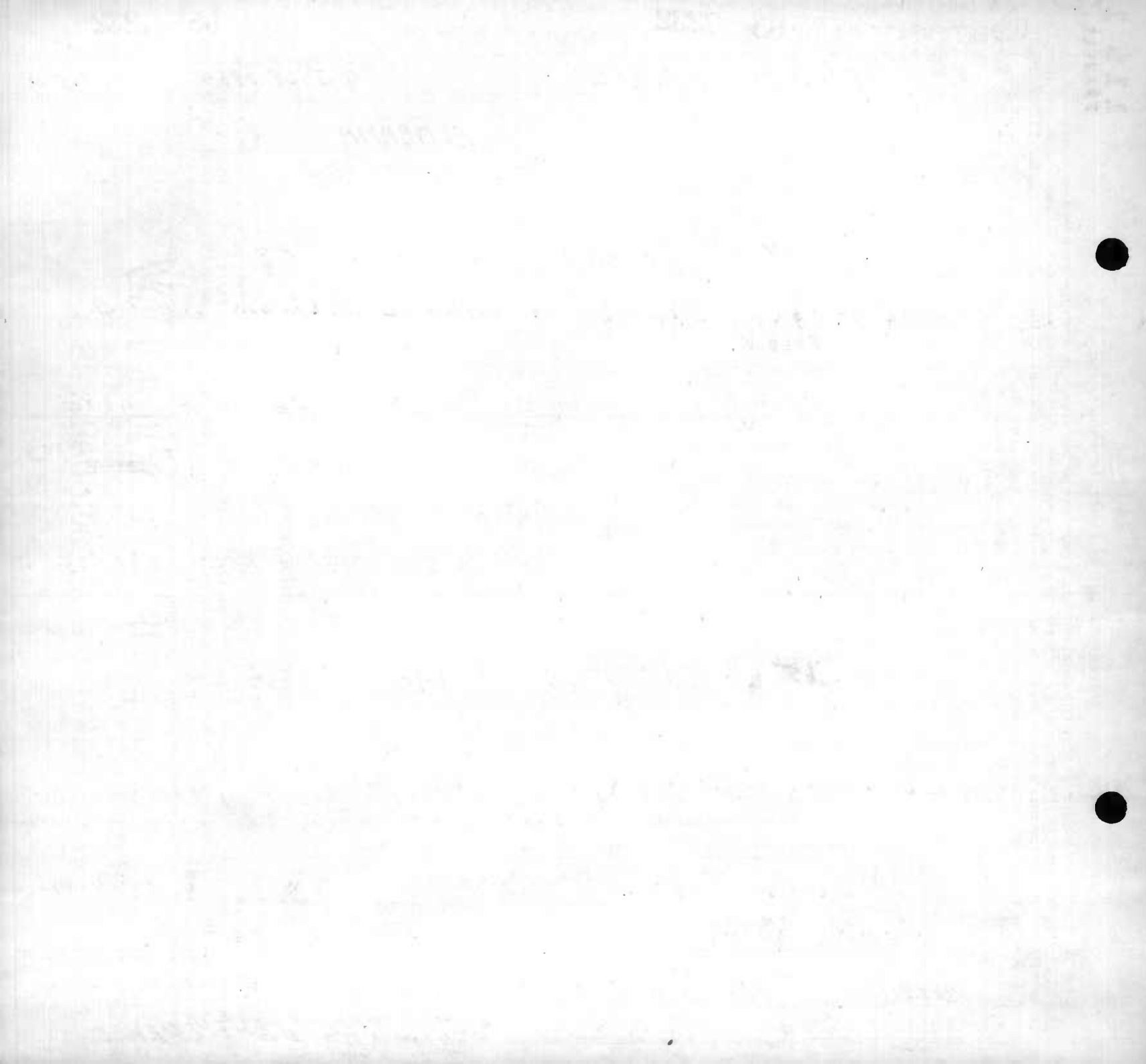


1151
FARWELL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 7232		CERTIFICATE OF DEATH		Registered No. 65 7232	
1. NAME OF DECEASED (Type or Print) FRED M. FARWELL				2. DATE AND HOUR OF DEATH 9 JULY 1965 8:45 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE ALABAMA B. COUNTY V-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) MONTROSE D. STREET ADDRESS (If rural, give location)					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 21 OCTOBER 1906	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CHICAGO ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRED M.				14. MOTHER'S MAIDEN NAME ANN DAVIS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Army		16. SOCIAL SECURITY NO. unknown		17. INFORMANT DOROTHY FARWELL - SAME		ADDRESS			
18. 737.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FUSION ANTERIOR CERVICAL SPINAL CERVICAL DISC DEGENERATION				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 45 MINUTES 1 DAY 3 YEARS			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE									
19A. DATE OF OPERATION 8 JULY 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DISC DEGENERATION		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5 JULY 1965 to 9 JULY 1965 , that (I) (we) last saw the deceased alive on 9 JULY 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Merwyn Bagan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 JULY 1965			
23C. PHYSICIAN'S NAME (Type) MERWYN BAGAN				23D. ADDRESS 320 RADNOR RD. BALTIMORE, 21212					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/12/65		24C. NAME of CEMETERY or CREMATORY Montrorse Cemetery		24D. LOCATION (City, town, or county) (State) MONTROSE - ALABAMA			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR John E. Fick		25C. FUNERAL DIRECTOR JACK LEWIS INC		ADDRESS 2107 N. FULTON PLACE			



BIRTH NO.		65 7233		BALTIMORE CITY HEALTH DEPARTMENT		65 7233	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. _____			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
FRANCIS L. GRANGER				July 10, 1965 11:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
St. Joseph's Hospital				Maryland Baltimore			
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
				Parkville			
				D. STREET ADDRESS (If rural, give location)			
				2507 Wycliff Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	Caucasian	Married	May 23, 1917	48			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Electro Plater		Metal		Balto. Md.		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown Granger				Mary M. Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes # 2				Mrs. Mildred L. Granger 2507 Wycliffe Rd.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Arteriosclerotic Heart Disease. DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/11/65	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		7 15 1965		Balto. U. S. National		Balto. Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
JUL 12 1965		Robert E. Fairbank		Mc Cully		130 E. Fort Ave	

VALLEY FORGE

PAID NOV 1901

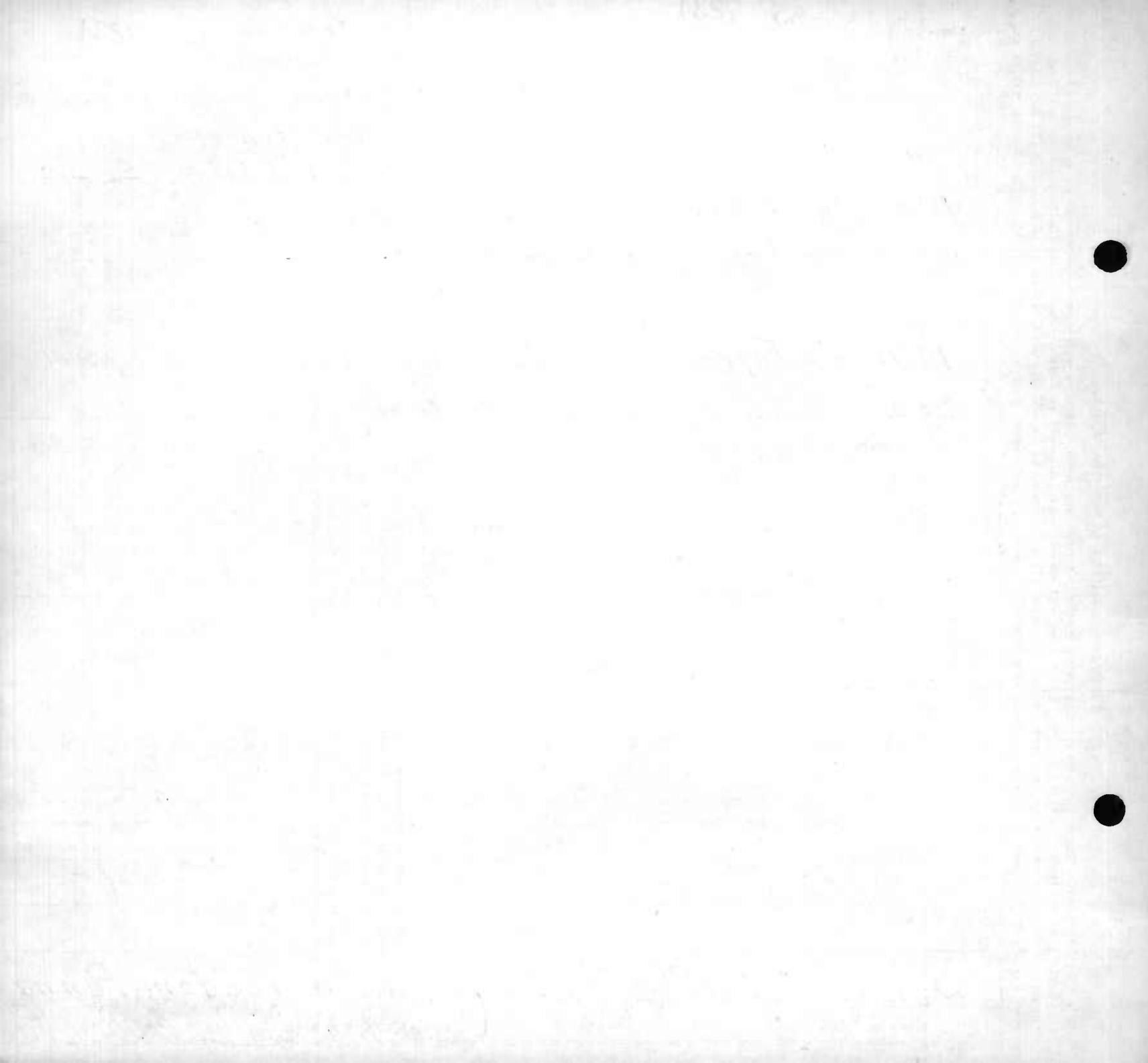
NOV 1901

Charles

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-1675665		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7234	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Paul Totman McGinnis				7/9/65 7:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
48 Maryland General Hospital				Md. Baltimore			
5. SEX				6. RACE			
male				white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
New Born				7/8/65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
				Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Milburn Eugene McGinnis				Mary Virginia Totman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT				ADDRESS			
mother				Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
anoxia due to							
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				abruptio placentae			
II				(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from July 8 1965 to July 9 1965, that (I) (we) last saw the deceased alive on July 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE, SIGNED			
Roland Doucet M.D.				7/9/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-10-65		New Freedom Cemetery		New Freedom, Penna.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 12 1965		Robert E. Fairbank M.D.		Jacob Hartenstein		New Freedom, Pa.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 7235					REGISTERED NO. 65 7235				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) BUMP, ORLANDO WEATHERS					2. DATE AND HOUR OF DEATH July 8, 1965 12:40 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3803 N. CHARLES ST.				
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/25/84	9. AGE (in years last birthday) 81	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CANAL ENGINEER			10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) MD. - Balto.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME ORLANDO FRANKLIN BUMP					14. MOTHER'S MAIDEN NAME SARAH WEATHERS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-44-4770		17. INFORMANT F. MRS MAUDE BUMP		ADDRESS SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 CARDIAC ARREST					INTERVAL BETWEEN ONSET AND DEATH 4 DAYS				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					(A) DUE TO (B) DUE TO (C) DUE TO				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from July 4 19 65 to July 8 19 65 , that (I) (we) last saw the deceased alive on July 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE L. EVAN CUSTER					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED July 8, 1965	
23C. PHYSICIAN'S NAME (Type) L. EVAN CUSTER					23D. ADDRESS UNION MEMORIAL HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE July-10-65		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore 21229			
25A. DATE REC'D BY HEALTH DEPT. JUL 12 1965		25B. NAME OF REGISTRAR Robert E. Farkner			25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co. 108-W-North-Av 21201				

END OF LINE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7236	
BIRTH NO. 65 7236		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STANISLAUS (Stanislaw) J. FILAR		2. DATE AND HOUR OF DEATH 7-10-65 10:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital		A. STATE Maryland B. COUNTY Howard			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Elkridge 63-00			
		D. STREET ADDRESS (If rural, give location) 6212 Old Washington Road,			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-13-92	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Filar		14. MOTHER'S MAIDEN NAME Constance Trela	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-2007		17. INFORMANT Elkridge, Md. ADDRESS Mrs. Kazmiera Filar-6212 Old Washington Rd.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) HYPERTENSION DUE TO (C) ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 1960 to 10 JULY 1965. that (I) (we) last saw the deceased alive on 10 JULY 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George E. Groleau		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12 July 65	
23C. PHYSICIAN'S NAME (Type) George E. Groleau		23D. ADDRESS M.D. 5608 Main Street, Elkridge, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-65		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
				24D. LOCATION (City, town, or county) (State) Dundalk Avenue, Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR R. E. F. J. J.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Avenue-21229	

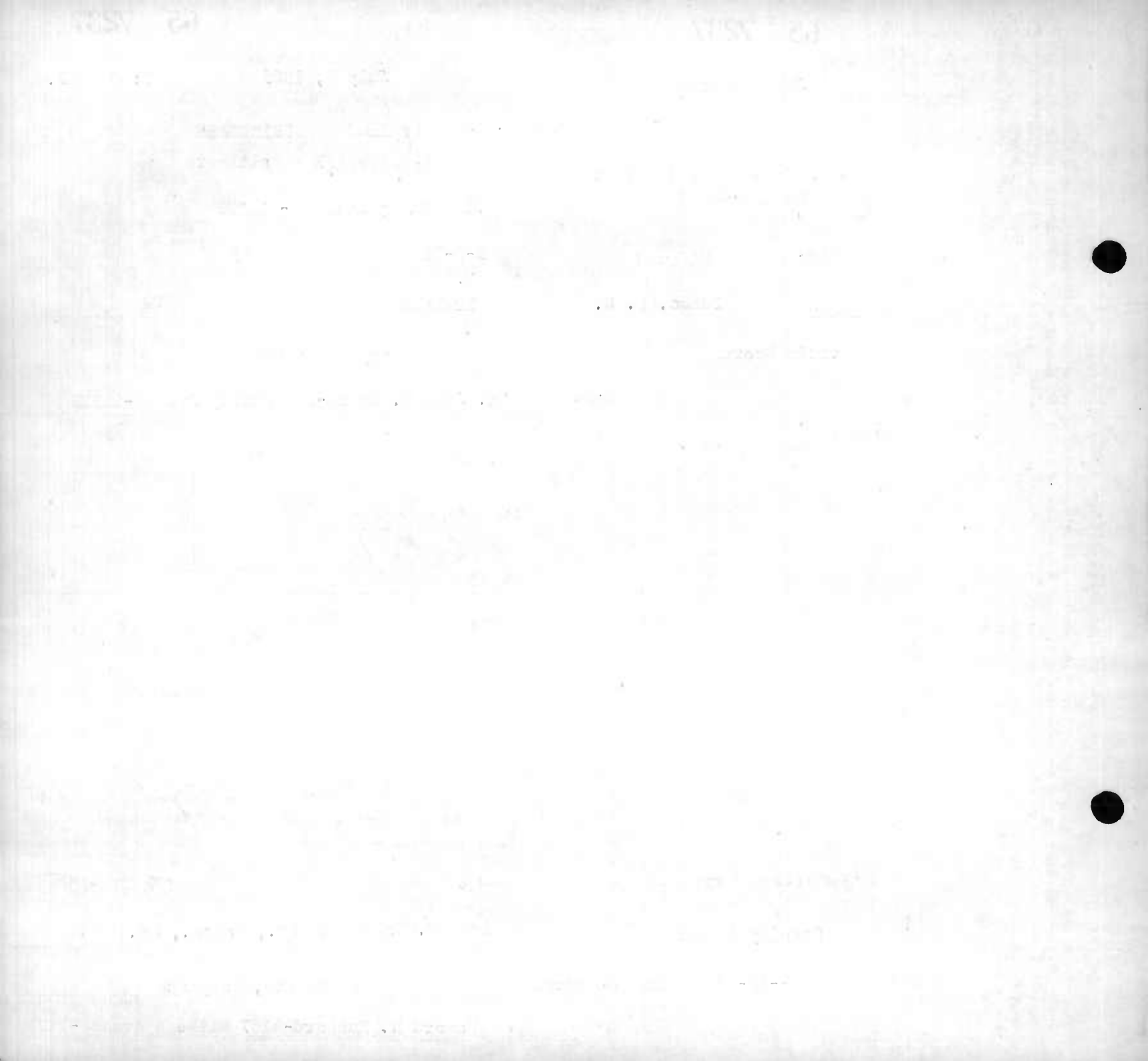
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101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

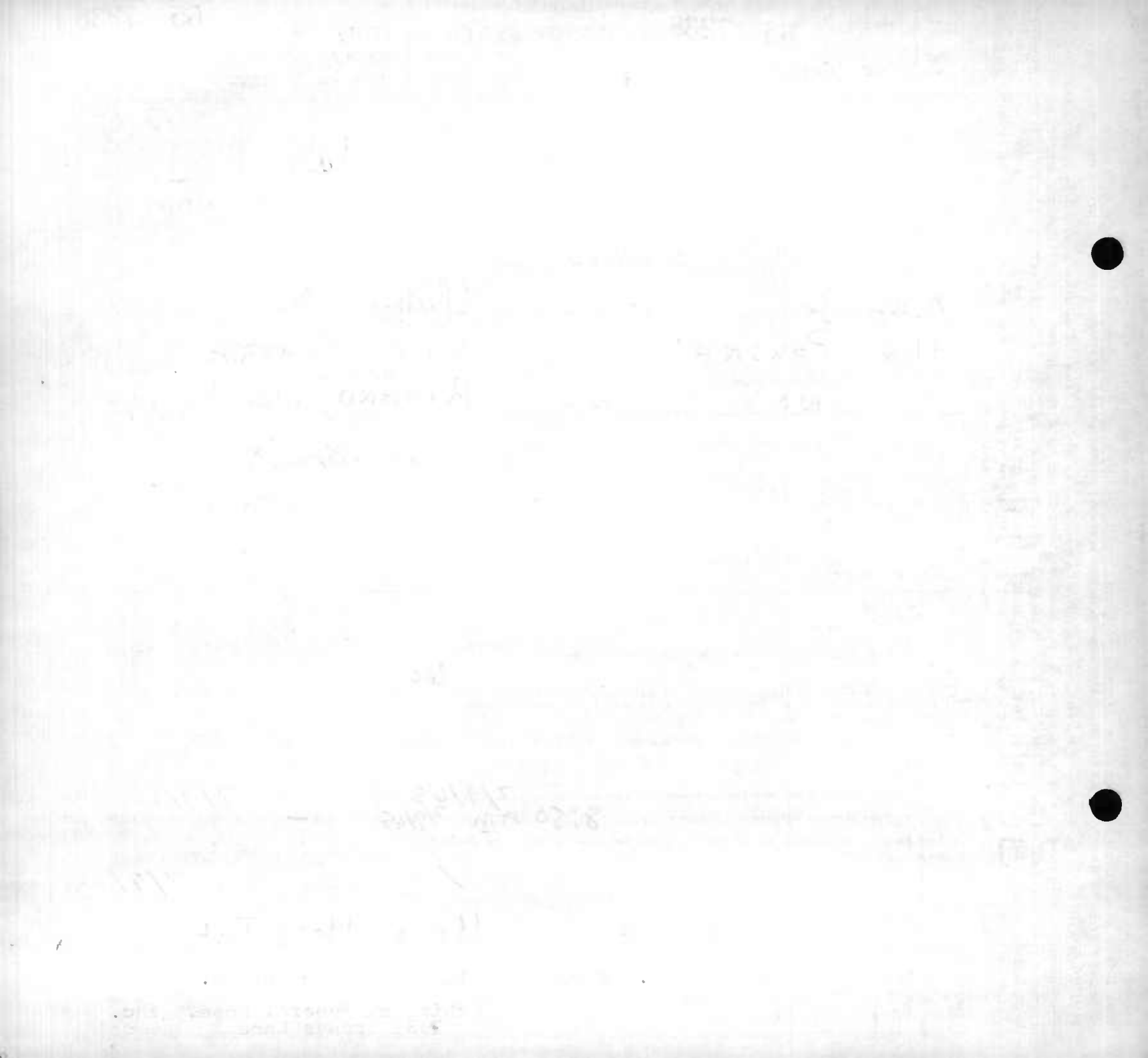
BIRTH NO. 65 7237				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 7237	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		P. M.	
				John Moore		July 8, 1965		7:40	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
90 Little Sisters of the Poor 1200 Valley Street				Maryland		XXXXXXXXXX 20-06			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		XXXXXXXXXX Baltimore			
				D. STREET ADDRESS (If rural, give location)		538 Hurley Avenue - 21223			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
Male		White		Widowed		3-9-1880		85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Engineer		Penna. R. R.		Ireland		USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Martin Moore				Mary Cosgrove					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				none		Mr. John F. Moore-538 Hurley Avenue-21223			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
420.1 I				Massive Myocardial					
ANTECEDENT CAUSES				(A) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
				A.S.C.U.					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 1964 to July 8 1965, that (I) (we) last saw the deceased alive on July 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Stanley Ankudas				7.12.65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Stanley Ankudas				1802 W. Baltimore St., Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7-13-65		New Cathedral		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 13 1965		Robert E. Farkman		Howard H. Hubbard-4107 Wilkens Avenue-21229					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

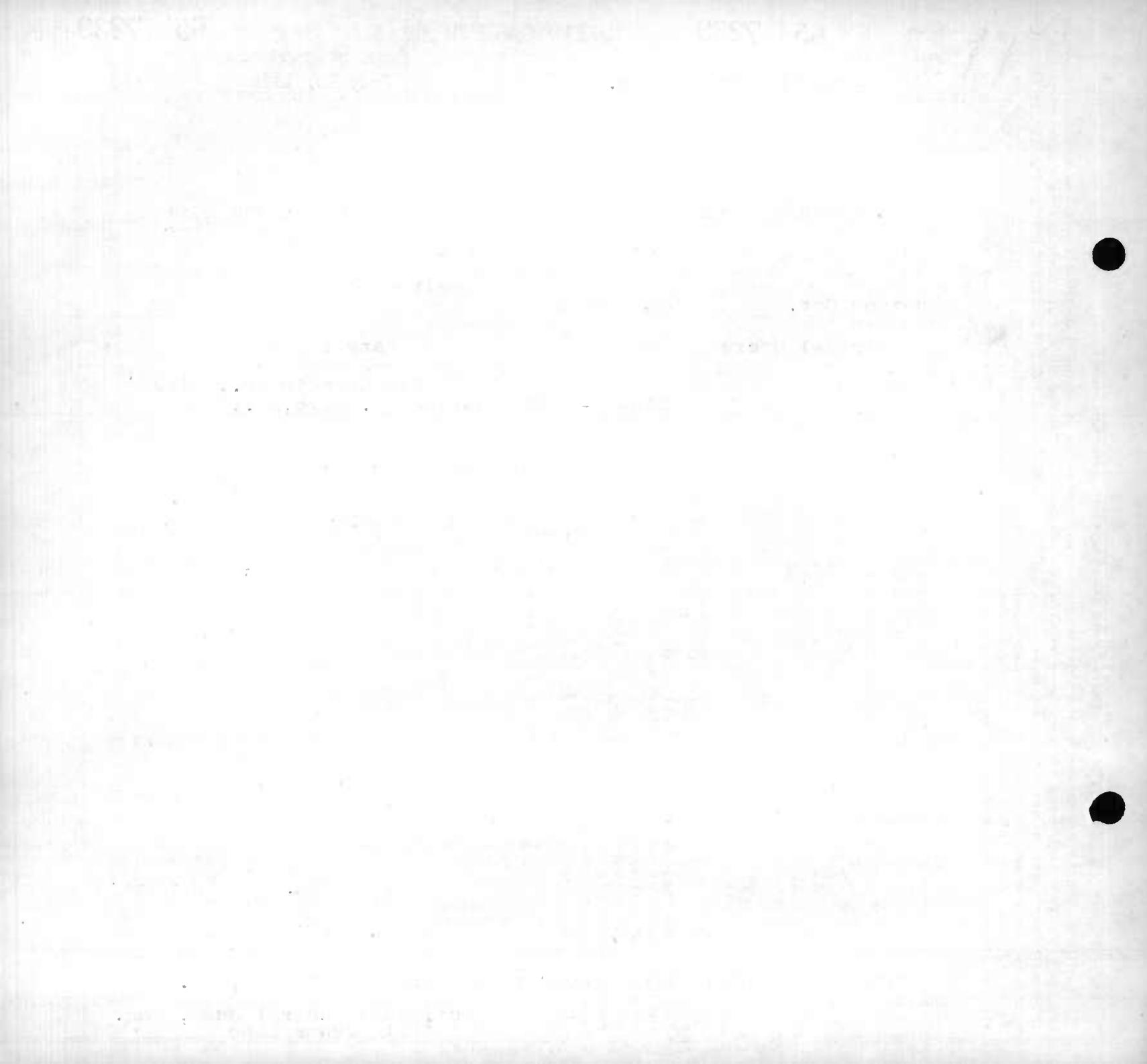
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7238	
BIRTH NO. 65 7238		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SADIE KUNASEK		2. DATE AND HOUR OF DEATH 7-9-65 18:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 17A			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) LINTHICUM 52-00			
38		D. STREET ADDRESS (If rural, give location) 202 SYCAMORE ROAD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-28-89	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Checkelvoekia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alex Pouska		14. MOTHER'S MAIDEN NAME Anna ? Roxxy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT above ADDRESS RIVARD, Mrs. George.	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMA of Breast DUE TO 2 widespread METASTASIS (B) 2 widespread METASTASIS DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Mo	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/9/65 19 to 7/9/65 19, that (I) (we) last saw the deceased alive on 8:50 AM 7/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert T. Stone		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/9/65	
23C. PHYSICIAN'S NAME (Type) ROBERT T. STONE		M.D. ADDRESS Univ. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/12/65		24C. NAME OF CEMETERY or CREMATORY St. Frances Cemetery	
		24D. LOCATION (City, town, or county) (State) Abingdon, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR R. E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

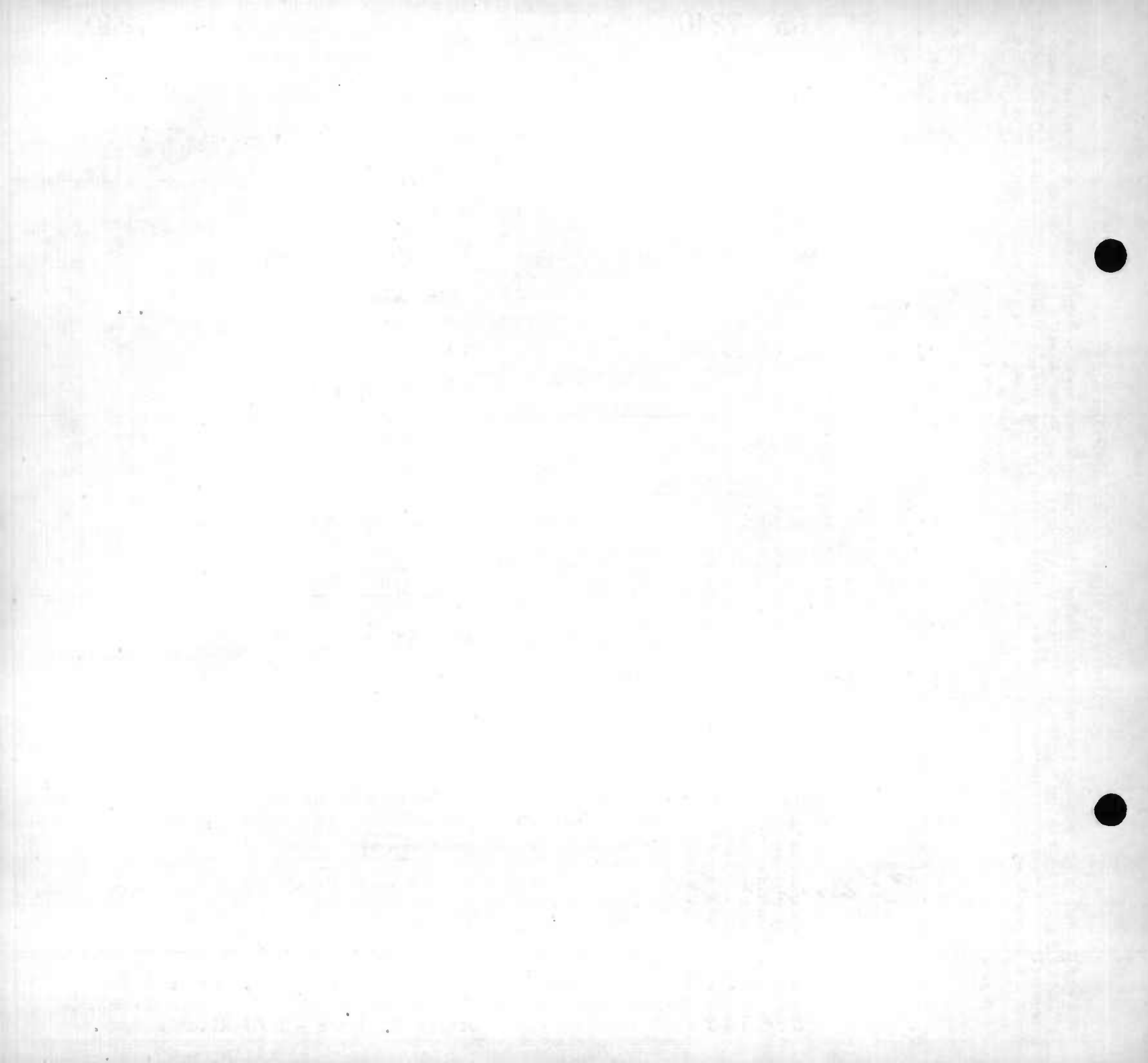
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 7239					CERTIFICATE OF DEATH			Registered No. 65 7239	
1. NAME OF DECEASED (Type or Print) Beere, Lawrence Paul Sr.					2. DATE AND HOUR OF DEATH July 10, 1965 7:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 41 St. Joseph Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6, D. STREET ADDRESS (If rural, give location) 4316 Parkside Drive				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5-14-39	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lynotype Opr.			10B. KIND OF BUSINESS OR INDUSTRY Balto. News Post		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Michael Beere					14. MOTHER'S MAIDEN NAME Mary ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-10-8755		17. INFORMANT ADDRESS 336 Lambeth Rd., 21228 Lawrence P. Beere, Jr., son				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 491X I Pulmonary edema; Bilateral BRONCHIAL ANTECEDENT CAUSES BRONCHIAL pneumonia; Duodenal ulcer DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 24 19 65 to July 10 19 65 , that (I) (we) lost saw the deceased alive on July 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Govinda Rao,					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 10, 1965		
23C. PHYSICIAN'S NAME (Type) Govinda Rao,					23D. ADDRESS 1400 N. Caroline Street #13				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/65		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

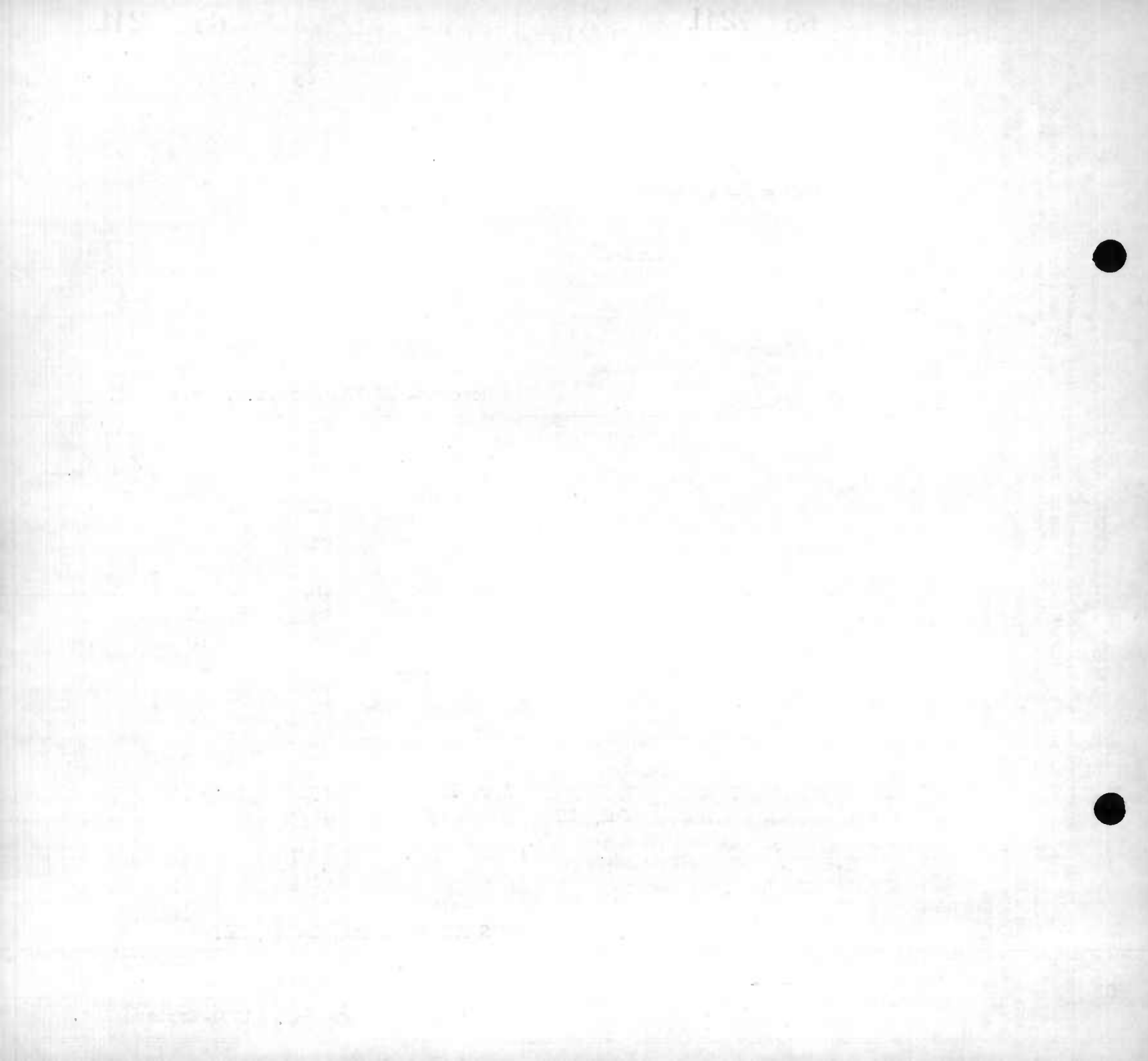
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 7240		CERTIFICATE OF DEATH		65 7240	
1. NAME OF DECEASED (Type or Print) ROSE FOPPIANO			2. DATE AND HOUR OF DEATH 7-7-65 12¹⁶ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 324 S. Exeter St.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED Widowed	8. DATE OF BIRTH 9-8-85	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Vincent Munte m u r o			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Chart, Hospital ADDRESS	
18. I 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. General Anesthetic			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 7-7-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Cell Carcinoma		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 25, 1965 to July 7, 1965 , that (I) (we) last saw the deceased alive on July 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theron J. Gonce M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7-7-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 10, 1965		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce - 4001 Ritchie Hwy. Baltimore 25, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7241				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7241			
M.E. CASE NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
(Type or Print)				GEORGE SCHWISOW				July 12, 1965 1; 20 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY							
US Public Health Service Hospital				Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Wyman Pk. Drive & 31st Street				Freeland				53-00			
D. STREET ADDRESS (If rural, give location)				Route 1 Box 5							
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
M		W		Married		6/2/04		61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Major				USA				Germany		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Albert Schwisow						Maria Schallenberger					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes USA 1943-1955				?		Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
II				Arteriosclerotic Cardiovascular Disease				Years			
ANTECEDENT CAUSES				(A) DUE TO							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO							
				(C) DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2								yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr. 16 1965 to July 12 1965, that (I) (we) last saw the deceased alive on July 12 1965 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Thomas Lau M.D.								23B. DATE SIGNED		7/12/65	
23C. PHYSICIAN'S NAME (Type) THOMAS LAU M.D.								23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial				7-15-1965		Scottdale		Scottdale, Pennsylvania			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JUL 13 1965				A. B. E. F. J. M. D.				Lilly & Zeiler Inc. 1901 Eastern Ave.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN ANDERSON

(E)

2. DATE AND HOUR PRONOUNCED DEAD

10 July 1965

4:10 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

528 Johansen St

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

9/7/21

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Anderson

14. MOTHER'S MAIDEN NAME

Louise Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes or unknown) (If yes, give war or dates of service)

Yes

N N 2

16. SOCIAL
SECURITY NO.

213-18-6297

17. INFORMANT

ADDRESS

Mrs Winona Anderson 3709 Forest Park Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

528 Johansen

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

July 10, 1965 3:58 a

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

jumped from 3rd floor window

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/14/65

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

VALLEY

NOV 19 1964

Clearing

FUNERAL DIRECTOR: IMPORTANT

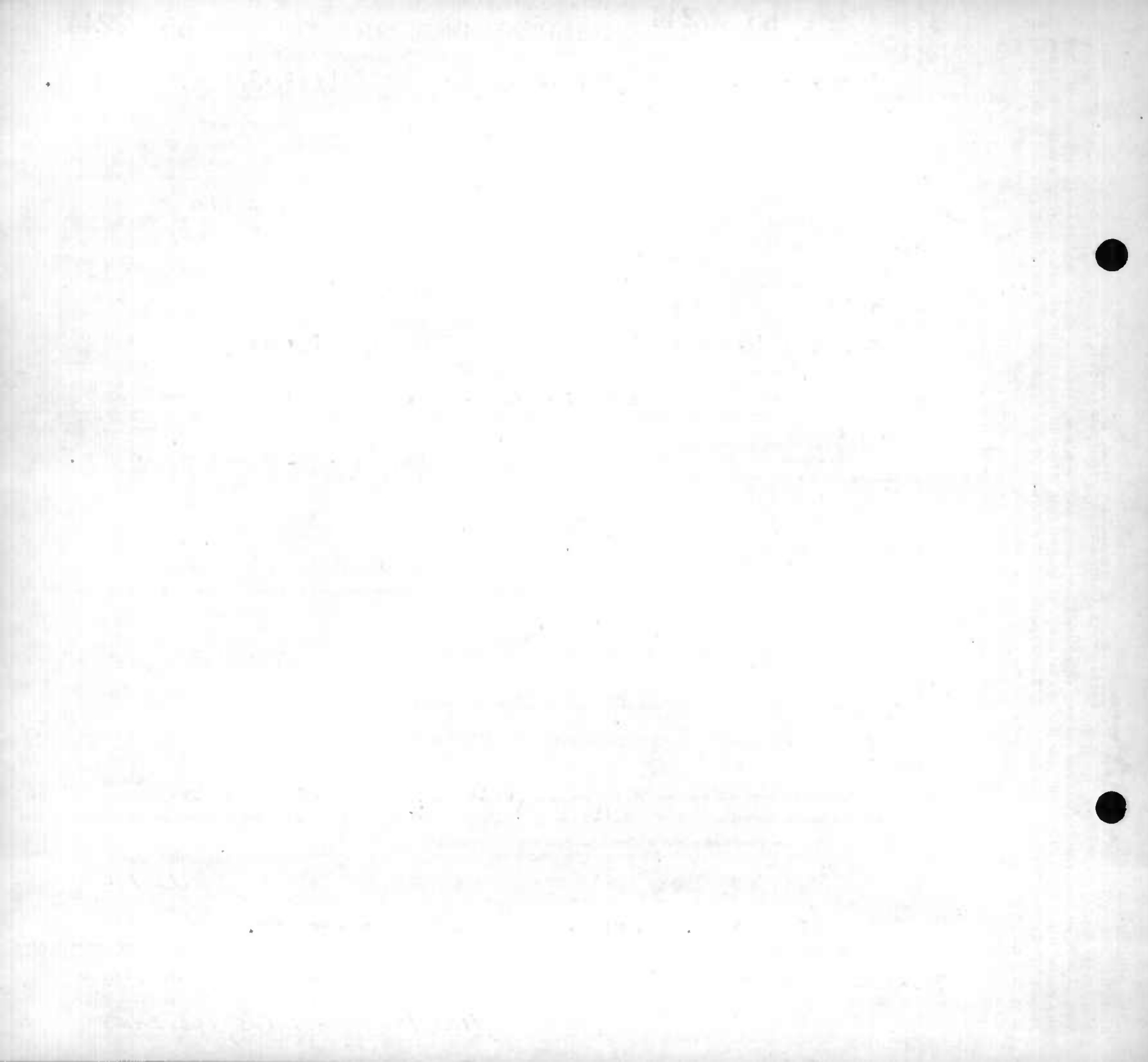
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 7243		CERTIFICATE OF DEATH		65 7243	
M.E. CASE NO.			1. NAME OF DECEASED		
			Margaret Johnson		
2. DATE AND HOUR OF DEATH			7/10/65 5:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
38 University			Maryland 22-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			615 S. Paca Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	Negro	Widowed	12/16/83	82	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Hawkins			Margaret Winder		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				M's Margaret Hogan 5010 The Alameda	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Myocardial Infarction		
ANTECEDENT CAUSES			(B) Coronary artery disease		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/12 1965 to 7/10 1965, that (1) (we) last saw the deceased alive on 7/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jonathan Tuerk M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				7/10/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JONATHAN TUERK M.D.				University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-15-65		Mt. Zion Cem.	
				24D. LOCATION (City, town, or county) (State)	
				Longgreen, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 13 1965		Robert E. Taylor, M.D.		Francis A. Hensley 578 W. Madison St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 7244</u>	
BIRTH NO. <u>65 7244</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARY SHADOCK (NEE) KARCZEWSKI</u>		2. DATE AND HOUR OF DEATH <u>July 10, 1965</u> <u>10:25P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>526 S. ELLWOOD AVENUE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-12-1895</u>	9. AGE (In years lost birthday) <u>69</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK KARCZEWSKI</u>		14. MOTHER'S MAIDEN NAME <u>DOROTHY MROZ</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-07-5546</u>		17. INFORMANT <u>MRS. BERNADINE BORDNER, 1952 SEARLES RD.</u>	
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January</u> 19 <u>52</u> to <u>July</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>July 8</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Clarence W. LeDoux</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/12/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux</u>		23D. ADDRESS <u>3023 Eastern Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-13-65</u>		24C. NAME of CEMETERY or CREMATORY <u>ST. STANISLAUS CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR <u>Nicholas T. MATTHEWS, 3021 EASTERN AVE.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is unknown, the physician must specify the cause of death. The certificate must be filled out as follows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased prior to death; (6) A physician who pronounced death was in regular attendance on the deceased prior to death; and (7) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

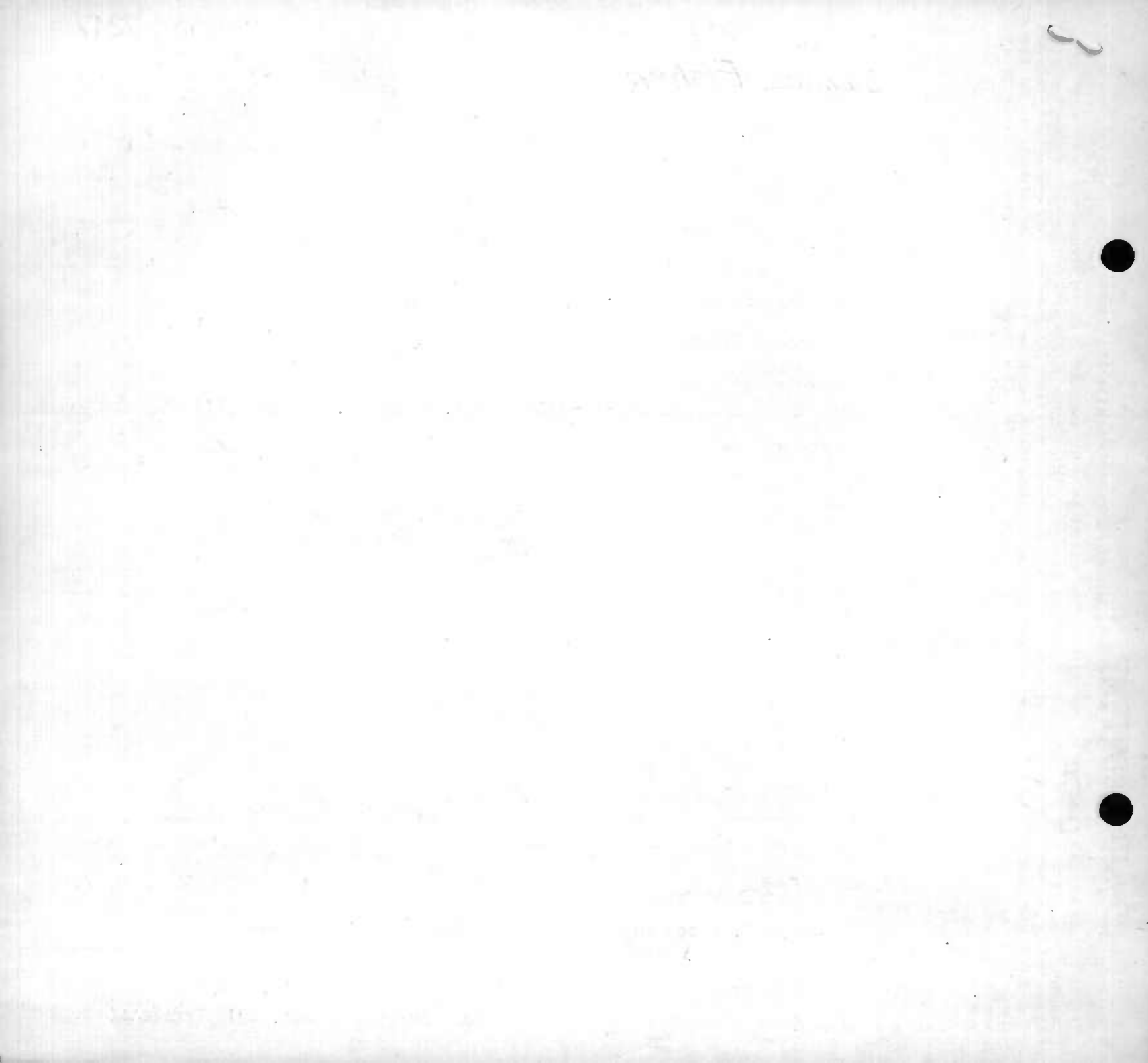
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 7246		65 7246	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MARY Jo WEBBER			July 10/65 2:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
SINAI HOSPITAL 42 BALTO. MD.			MARYLAND P. Geo.		
C. CITY OR TOWN (If outside city limits, write STATE and County)			D. STREET ADDRESS (If rural, give location)		
HYATTSVILLE 66-80			6900 Highview Terrace Apt 301		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
FEMALE	WHITE	MARRIED	9/15/42	22	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE		AT HOME	BALTO. MD		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
LAFAYETTE WEINBERG			NORMA SEIDENMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
NO		219-42-0048	MR. Stephen J. WEBBER		6900 Highview Terrace HYATTSVILLE, MD.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			Respiratory Failure 2 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			Disseminated Sclerosis 5 mos		
II			(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from March 10 19 65 to July 10 19 65, that (I) (we) last saw the deceased alive on 23 12-M 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leonard Wallenstein M.D.				7/10/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
W. A. CLESTER M.D.		848 W 36th BALTO. MD			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL	7/12/65	Hebrew Friendship		BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 13 1965		R. B. E. Fisher, M.D.		Sol LEVINSON & Sons, Inc 6010 Reisterstown Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

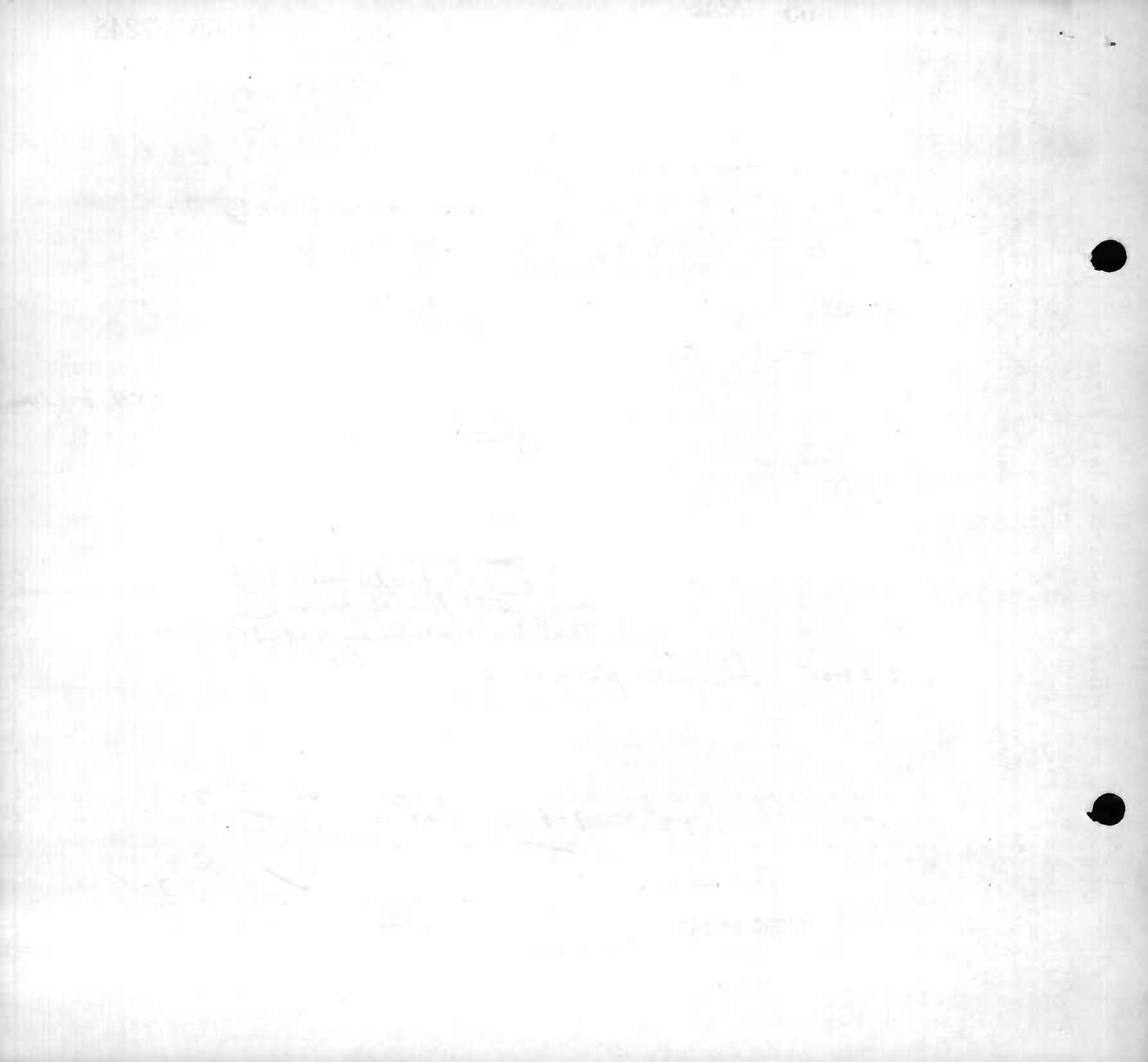
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 7247</u>	
BIRTH NO. <u>65 7247</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>65 7247</u>		1. NAME OF DECEASED (Type or Print) <u>Samuel H. Fisher</u>		2. DATE AND HOUR OF DEATH <u>7/10/65 - 5:01 pm</u> <u>5:01 P M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>#</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4111 - Kathland Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>8/12/00</u>	9. AGE (In years lost birthday) <u>64</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>News Stand Proprietor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Morris Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-3374</u>	17. INFORMANT <u>Mrs. Samuel H. Fisher</u>		ADDRESS <u>4111 Kathland Avenue</u>
18. <u>410 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Congestive Heart Failure</u> DUE TO (B) <u>Rheumatic Heart Disease with</u> DUE TO <u>mitral insufficiency and aortic stenosis</u> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>50 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 5,</u> 19 <u>65</u> to <u>July 10,</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>July 10,</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Blockman</u>				23B. DATE SIGNED <u>July 10, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blockman</u>		23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 11/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Har Zion Tifereth Israel</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. 6010 Reisterstown Road</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

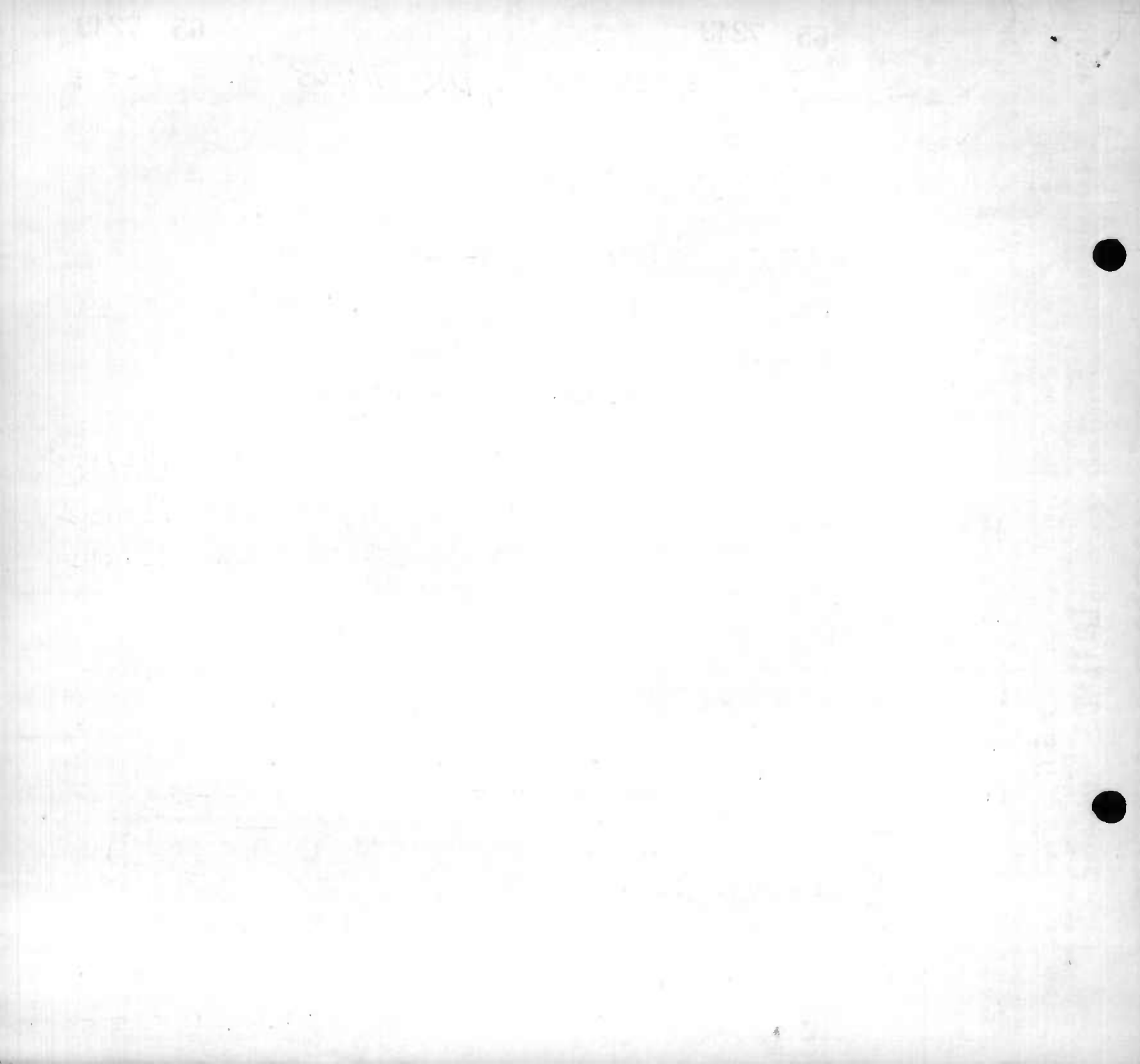
BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department	
65 7248				65 7248	
BIRTH NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) REBECCA CHASANOV				2. DATE AND HOUR OF DEATH July 8, 1965 1:50 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND, Inc. 46				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 6-02 D. STREET ADDRESS (If rural, give location) 115 N. LUZERNE AVE	
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 86	9. AGE (In years at birth) 86	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME MONES CHASNOV		
14. MOTHER'S MAIDEN NAME LEAH ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT MR. MORTON CHASE 6002 Berkeley Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 + 260X Acute pulmonary edema terminal bronchopneumonia			INTERVAL BETWEEN ONSET AND DEATH 1-2 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Strangulated femoral hernia Diabetes mellitus atrial fibrillation w/ LBBB			(B) Internal bleeding 2-3 days		
(C) Coronary insufficiency w/ final fatal bundle branch block 6 weeks or so					
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1 6-23-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Strangulated femoral hernia		20A. AUTOPSY? (Yes or No) 0	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-23 19 65 to 7-8 19 65 , that (I) (we) last saw the deceased alive on 7-8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bernas				23B. DATE SIGNED 7-8-65	
23C. PHYSICIAN'S NAME (Type) ELVIRO BERNAS				23D. ADDRESS LUTHERAN Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/65		24C. NAME of CEMETERY or CREMATORY Lubowitz Nosi Ari	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965			
25B. NAME OF REGISTRAR Robert E. Farkes, M.D.		25C. FUNERAL DIRECTOR ADDRESS Sol LEVINSON + Bros. INC. 6010 REGISTER TOWN RD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

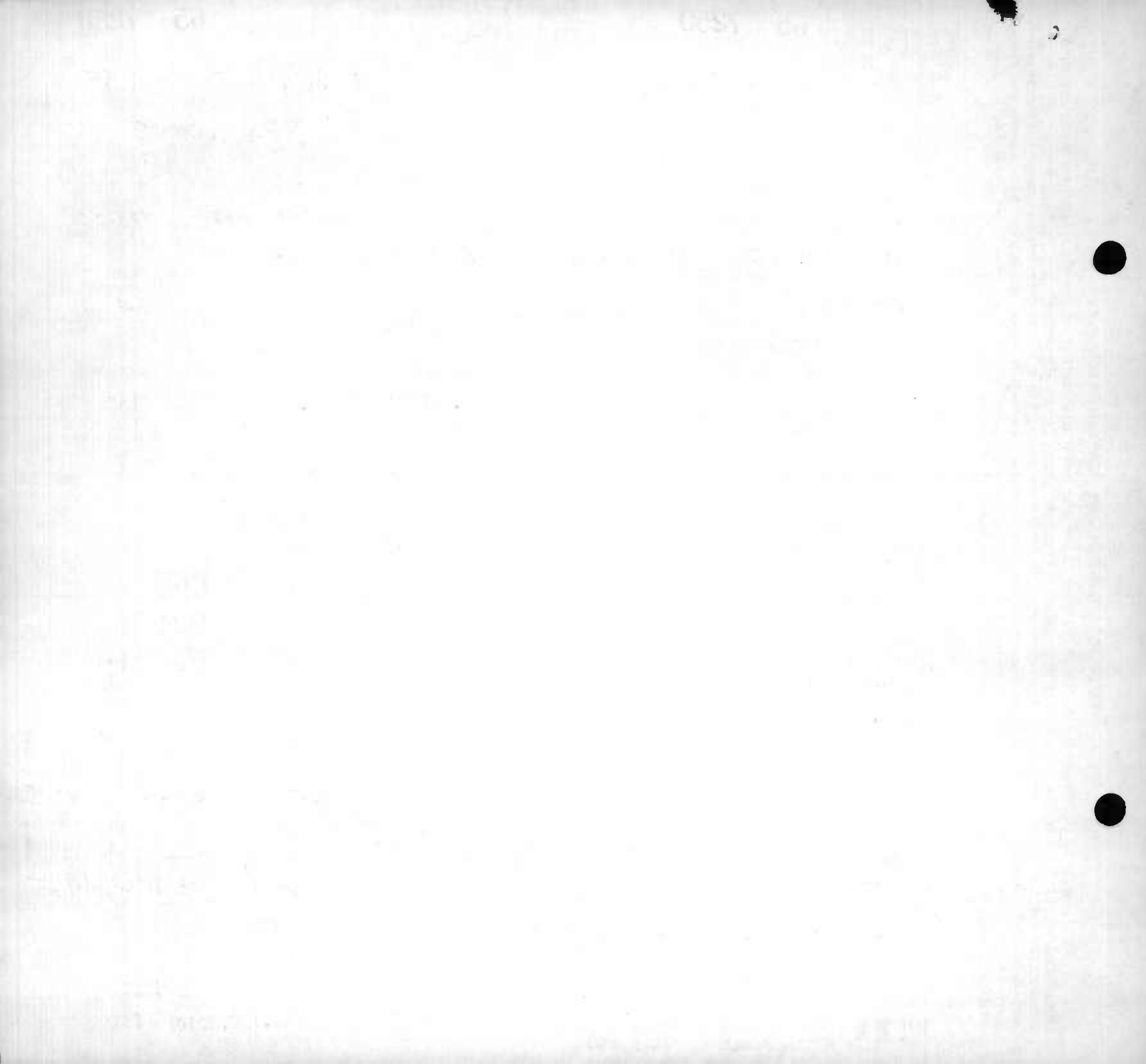
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7249	
BIRTH NO. 65 7249		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THALHEIMER, ALVIN, DR.		2. DATE AND HOUR OF DEATH 7/8/65 7:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND		B. COUNTY 27-15	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 5603 ROXBURY PLACE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7-13-94	9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY BUSINESS		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAMUEL THALHEIMER		14. MOTHER'S MAIDEN NAME MERLE FRIEDENWALD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-1839		17. INFORMANT HOSPITAL RECORDS ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (? INFARCT) MYOCARDIAL FAILURE (A) DUE TO CORONARY INSUFFICIENCY (B) DUE TO ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE (C)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours. 12 years 12 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22-65 19 to 7-8-65 19, that (I) (we) last saw the deceased alive on 7-8-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen Dress Johnson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7/8/65	
23C. PHYSICIAN'S NAME (Type) ALLEN DRESS JOHNSON, M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/11/65		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION BALTIMORE MARYLAND		24E. DATE REC'D BY HEALTH DEPT. JUL 13 1965		24F. NAME OF REGISTRAR Robert E. Johnson	
24G. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD.		24H. DATE REC'D BY HEALTH DEPT. JUL 13 1965		24I. NAME OF REGISTRAR Robert E. Johnson	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

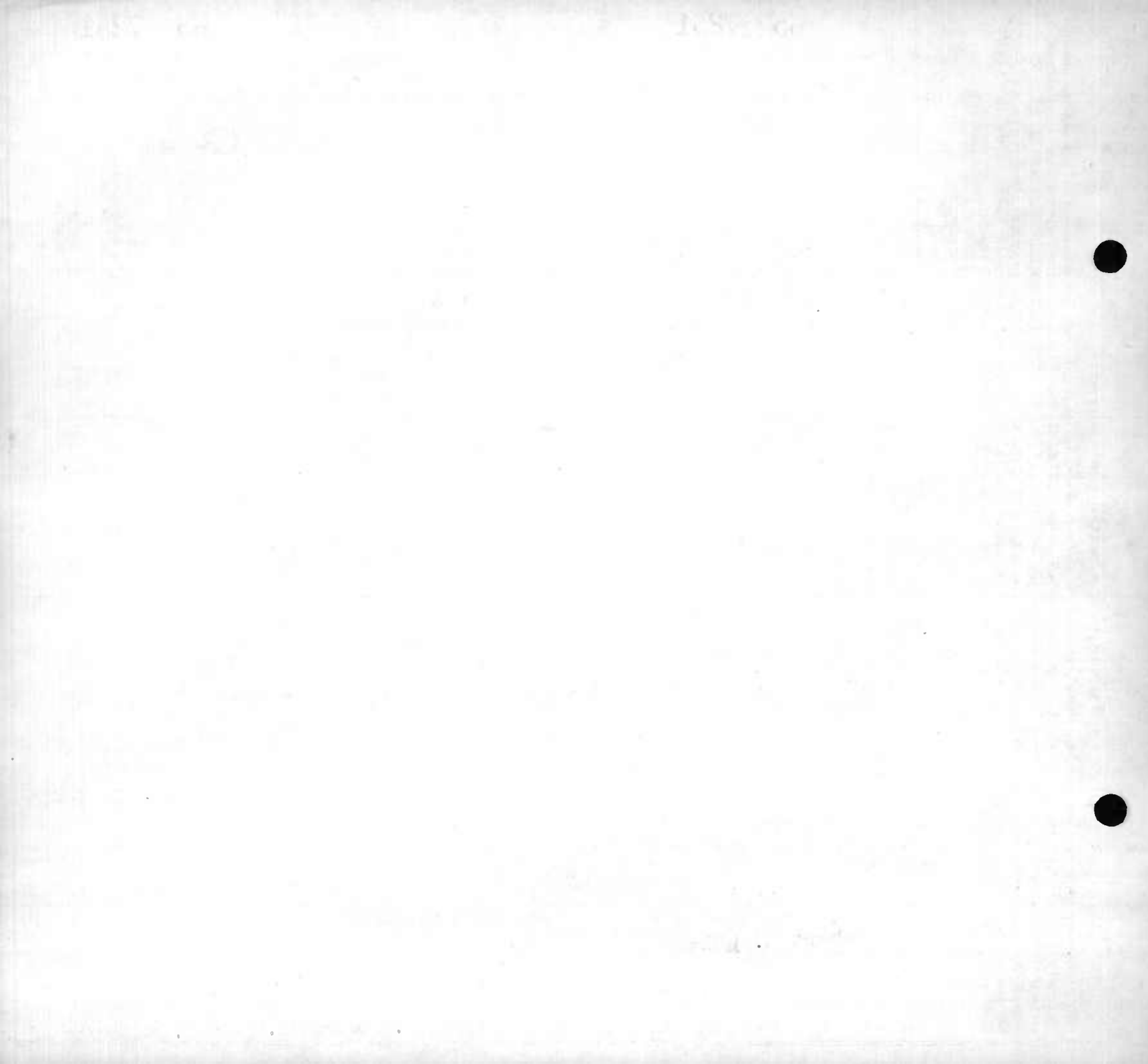
BIRTH NO. 65 7250		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7250	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOSEPH GOLOMB		2. DATE AND HOUR OF DEATH 9 JULY 1965 11:35 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 2711 A HANSON AVE APT 2A					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-31-96	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE SALESMAN		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME JACOB GOLOMB		14. MOTHER'S MAIDEN NAME ROSE BERMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 913-03-8419		17. INFORMANT MR. HERMAN TAPPER 6903 DORSET PLACE	
18. I 451X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) MASSIVE HEMORRHAGE (A) DUE TO RUPTURED ABDOMINAL ANEURYSM (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 19 JULY 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ANEURYSM		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9 JULY 1965 to 9 JULY 1965, that (I) (we) lost saw the deceased alive on 9 JULY 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hawthorne N. Banez M.D.		Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9 JULY 1965	
23C. PHYSICIAN'S NAME (Type) HAUTHORNE N. BANEZ M.D.		23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/11/65		24C. NAME of CEMETERY or CREMATORY AGUDAS ACHIM ANSHE SFARD	
24D. LOCATION (City, town, or county) (State) ROSEDALE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

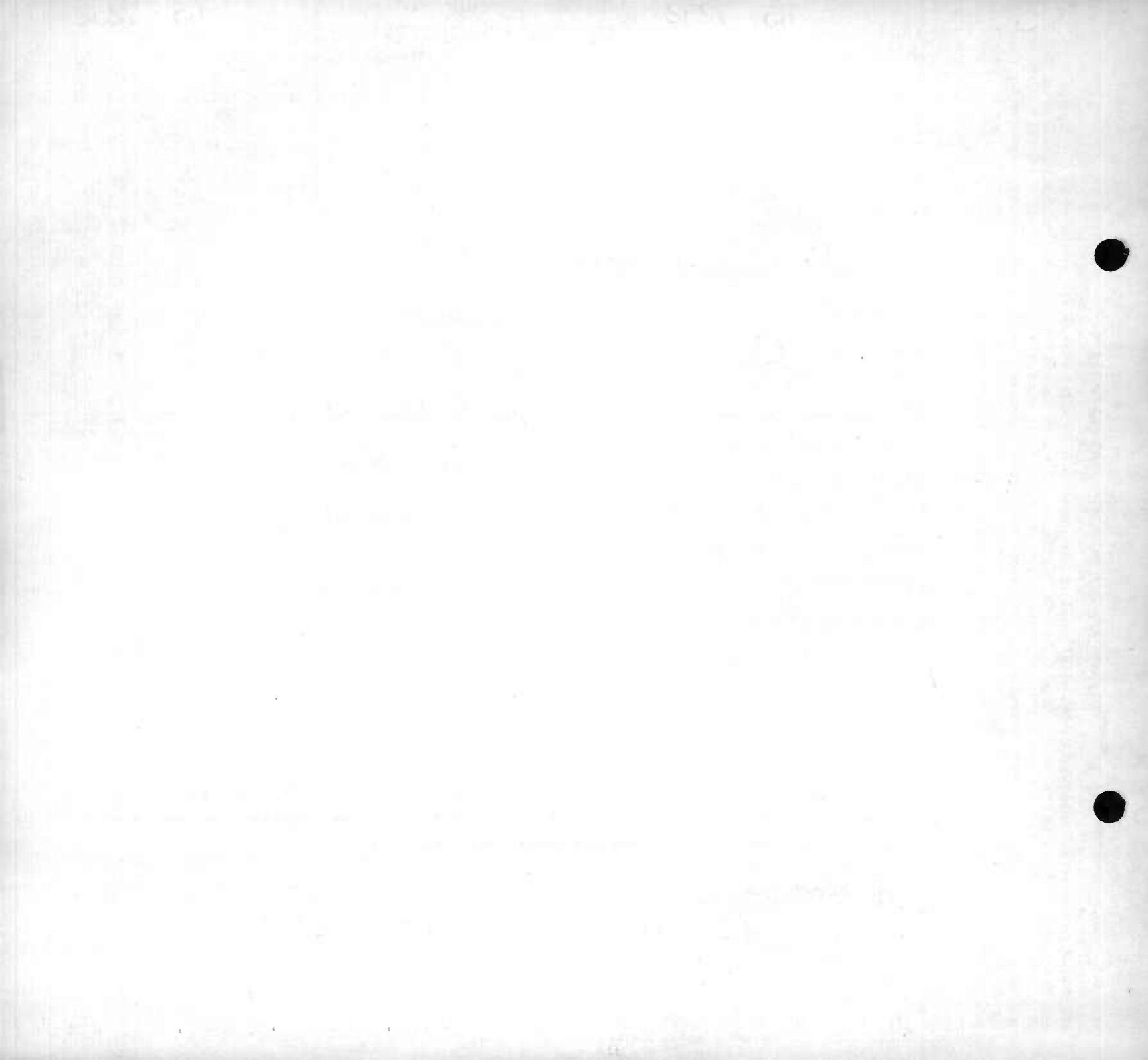
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7251	
BIRTH NO. 65 7251		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Burgess, Saida E</i>			2. DATE AND HOUR OF DEATH <i>7-9-65 9 56 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland General Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9-01</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>3905 Old York Rd. 21218</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12-1-77</i>	9. AGE (In years last birthday) <i>87</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Samuel Davis</i>			14. MOTHER'S MAIDEN NAME <i>Rebecca Ebert</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Hospital chart</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>586X I</i> <i>Cardiac arrest</i> (A) DUE TO <i>Laryngeal edema</i> (B) DUE TO <i>cholecystectomy</i> (C) DUE TO <i>atrial fibrillation</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> <i>30 min</i> <i>72 hrs.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>7/6/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>lesion, ascending colon</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6 July 1965</i> to <i>9 July 1965</i> , that (I) (we) last saw the deceased alive on <i>9 July 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Robert L. Holt</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>9 July 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert L. Holt</i>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/12/1965</i>	24C. NAME of CEMETERY or CREMATORY <i>Pleasant Grove Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Monrovia, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran Inc. 3000 E. Baltimore St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

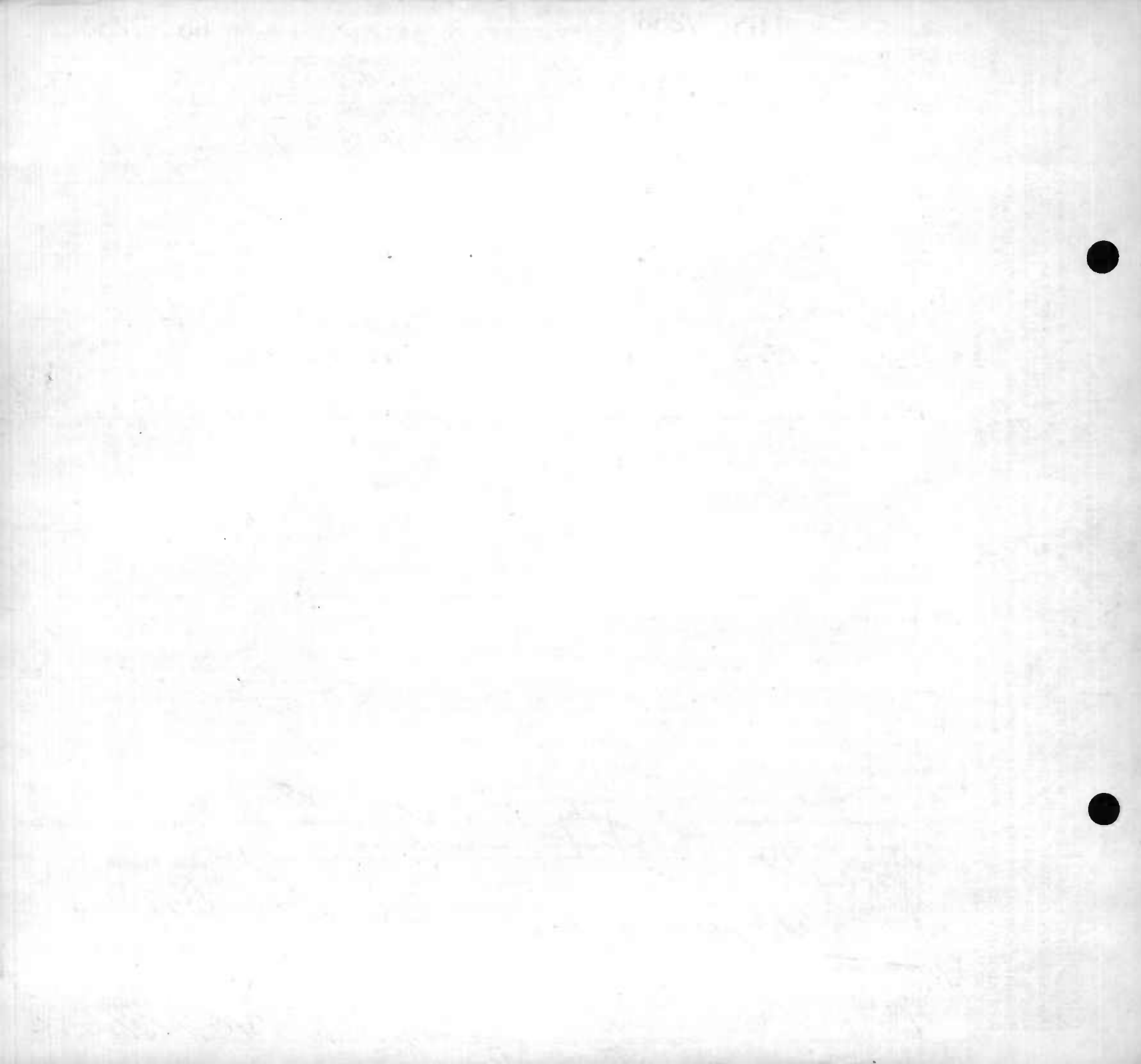
BALTIMORE CITY HEALTH DEPARTMENT									
65 7252					65 7252				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>SELMA I. SIMON</u>					2. DATE AND HOUR OF DEATH <u>July 9, 1965</u> <u>7 45</u> P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSP</u> <u>BALTO MD.</u>					A. STATE <u>MD.</u> B. COUNTY <u>27-05</u>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO #6</u>				
					D. STREET ADDRESS (If rural, give location) <u>6600 ALTA AVE</u>				
5. SEX <u>F</u>	6. RACE <u>CAU</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-7-04</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>HERMAN CROWLEY</u>					14. MOTHER'S MAIDEN NAME <u>ELIZABETH HAUGT</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>CHART</u>		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u>					CAUSE OF DEATH <u>CHRONIC RENAL DISEASE</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>6/29</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>UREMIA (DIALYSIS)</u>			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> 19 <u>65</u> to <u>7/9</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Donald T. Lewers</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>7/9/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONALD T. LEWERS</u>					23D. ADDRESS M.D. <u>MD. GENERAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/12/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1965</u>			25B. NAME OF REGISTRAR <u>John A. Morgan Inc.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7253		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 7253	
1. NAME OF DECEASED (Type or Print) SYLVIA FULTON			2. DATE AND HOUR OF DEATH JULY 12, 1965 10:50 AM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital			A. STATE New York City B. COUNTY V-29		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location) 365 W. 118 St		
5. SEX F	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 2-1-1950	9. AGE (In years last birthday) 15	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA.			13. FATHER'S NAME Eddie Fulton		
14. MOTHER'S MAIDEN NAME Edwina Mouzon			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT Edwina Mouzon		
ADDRESS N.Y.N.Y. 365 W. 118 St					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED ACUTE PURULENT PERITONITIS sec. TO RUPTURED APPENDICITIS			CAUSE OF DEATH four days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH three days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 12/65 19 65 to July 12 19 65 , that (I) (we) last saw the deceased alive on July 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. M. H. Polito				23B. DATE SIGNED 13 July 65	
23C. PHYSICIAN'S NAME (Type) Dr. M. H. Polito				23D. ADDRESS Bon Secours Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
July 16/1965		7/16/65		Ferncliff Cem	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
Hartsdale New York		JUL 13 1965			
25A. NAME OF REGISTRAR Robert E. Taylor		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR George A. L...	
ADDRESS		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7254				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7254	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harry E. Doron				2. DATE AND HOUR OF DEATH 7-10-65 11 45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital				A. STATE Maryland B. COUNTY 19-04			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 1821 Frederick Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-9-83	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Doron (Dec.)				14. MOTHER'S MAIDEN NAME Belle May Weber (Dec.)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-05-3069		17. INFORMANT wife MARGARET D. DORON		ADDRESS 1821 FREDERICK AVE	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				6 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerotic Heart Disease				40 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Aortic Insufficiency							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 2 19 65 to July 10 19 65 , that (I) (we) last saw the deceased alive on July 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Michael Gould				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-65	
23C. PHYSICIAN'S NAME (Type) W. MICHAEL GOULD				23D. ADDRESS M.D., GEN. HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-14-65		24C. NAME OF CEMETERY or CREMATORY LOUISON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Fairley, M.D.		25C. FUNERAL DIRECTOR Frederick A. ...		ADDRESS 1915 W. Baltimore	

ON

9000

Wm. H. H. H. H.

03. 11. 20

2014 5

22

X

plant

CERTIFICATE OF DEATH

Registered No. 65 7255

BIRTH NO.

65 7255

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK Frank Majka

2. DATE AND HOUR OF DEATH

July 11, 1965

8:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1106 S. Linwood Avenue #21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

1-22-17

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MACHINIST

10B. KIND OF BUSINESS OR INDUSTRY

CONTINENTAL

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOCENTY MAJKA

14. MOTHER'S MAIDEN NAME

WEBER

15. Was Deceased Ever in U.S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL
SECURITY NO.

21603-7779

17. INFORMANT

HELENE MAJKA, 1106 S. Linwood Ave

18. 287 X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Septicemia
DUE TO

2 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B) Pneumonia
DUE TO

2 Days

(C) Cardio-Pulmonary Insufficiency with 1 Month
Exogenous ObesityII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Massive Exogenous Obesity

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1, 1965 to July 11, 1965,
that (I) (we) last saw the deceased alive on July 11, 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

July 11, 1965

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard K. Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION
REMOVAL (Specify)

BURIAL

24B. DATE

7/15/65

24C. NAME OF CEMETERY or CREMATORY

ST. STANISLAUS CEM

24D. LOCATION

(City, town, or county)

8515 BOSTON ST, MD

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

25B. NAME OF REGISTRAR

Robert E. Faldut

25C. FUNERAL DIRECTOR

Marie Faldutsky 10005 KENWOOD AVE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decayed body; (6) A hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BOCENITJ
WACHINIST

INC. 30

WASKA
CONTINENT

21603-1114

MD
HASTO

HERE
WEDER

More
F-15
F-16

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 7256

BIRTH NO. 65 7256

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Alice Marie Dukes

2. DATE AND HOUR OF DEATH

7-11-65

3:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1017 Leadenhall Street - #21230

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12-22-03

9. AGE (in years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charlie Owens

14. MOTHER'S MAIDEN NAME

Lillie Murphy

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue-21224

18. I 171X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Cervix
DUE TO

6 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-5 19 65 to 7-11 19 65,
that (I) (we) lost saw the deceased alive on 7-11 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-11-65

23C. PHYSICIAN'S
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

BCH-4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-14-65

24C. NAME OF CEMETERY or CREMATORY

Mount Calvary Ct

24D. LOCATION

A.A.CO., MD.

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

25B. NAME OF REGISTRAR

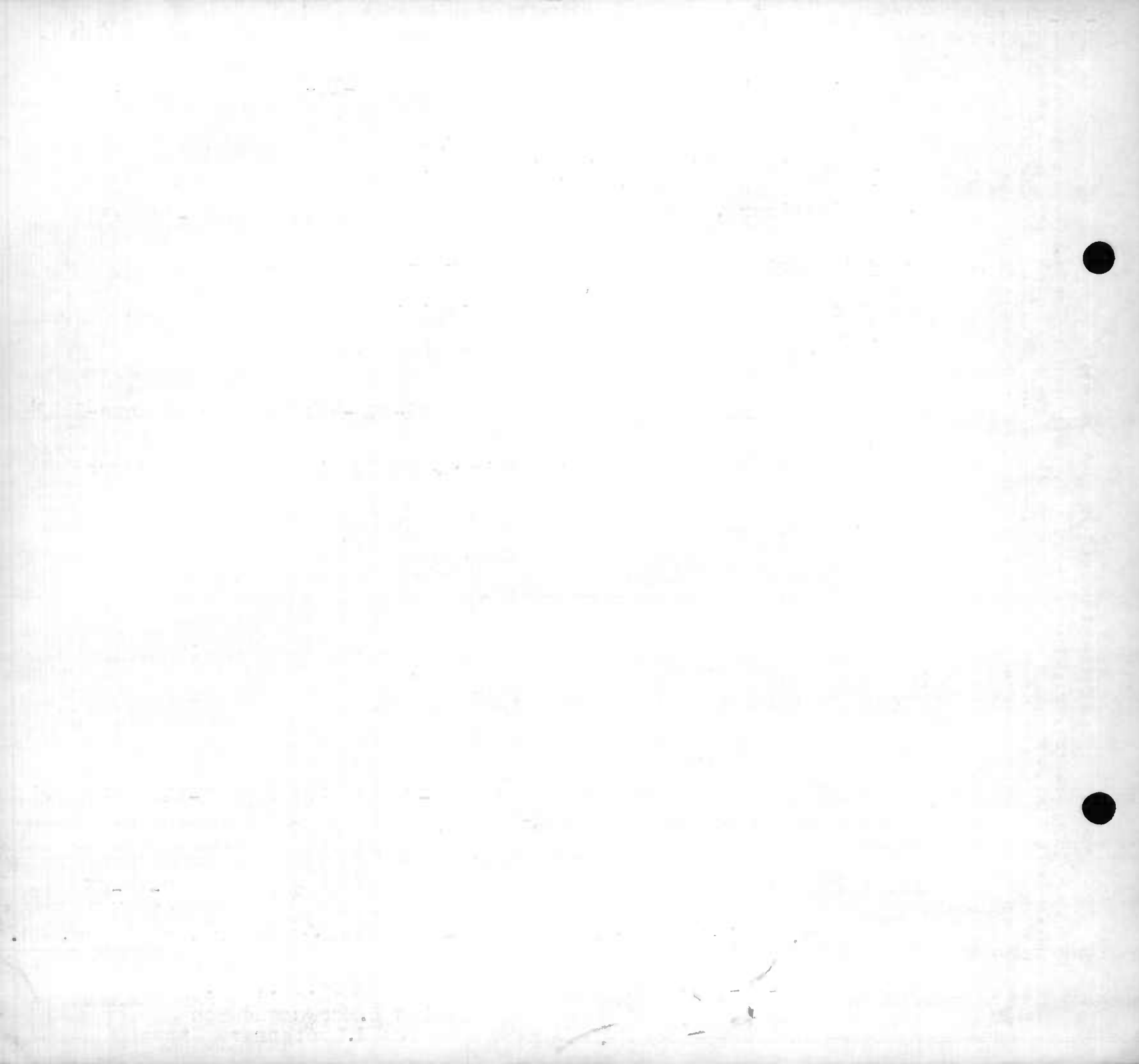
A. L. E. F. F. F.

25C. FUNERAL DIRECTOR

Isalah L. Brown and Son

ADDRESS

108 W. Montgomery Street



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7257		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7257	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) EMANUEL WATSON			2. DATE AND HOUR OF DEATH July 11, 1965 12 AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE CORRECTED 7-14-65			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 23-01		
5. US Public Health Service Hospital Wyman Pk. Drive & 31st Street			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 945 S. Sharpe St.					
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/1/95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamen		10B. KIND OF BUSINESS OR INDUSTRY Seafarer	11. BIRTHPLACE (State or foreign country) BWI. US		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Manuel Watson			14. MOTHER'S MAIDEN NAME Susan Gordon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. ---		16. SOCIAL SECURITY NO. 218 09 1965	17. INFORMANT ADDRESS Records-USPHS Hospital Balto. Md/		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15501 Primary Carcinoma of the Liver			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II			INTERVAL BETWEEN ONSET AND DEATH Months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that h (this hospital) attended the deceased from Apr. 6, 19 65 to July 11, 10th 19 65 , that h (we) last saw the deceased alive on July 10, 19 65 and that in h (our) opinion death occurred on the date and hour and from the causes stated above. h (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas Lau, MD				23B. DATE SIGNED 7/11/65	
23C. PHYSICIAN'S NAME (Type) Thomas Lau M.D.				23D. ADDRESS USPHS Hospital, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-65		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Ct	
24D. LOCATION (City, town, or county) (State) A.A. A.CO., MD					
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Isaiah L. Brown and Son	
				ADDRESS 100 W. Montgomery Street	

BIRTH NO. 65 7258 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7258

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

VATEL WILSON

2. DATE AND HOUR PRONOUNCED DEAD

7-12-65

1:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph's Hospital - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1729 N. Broadway

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 27, 1909

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Postal Worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Amherst Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John F. Wilson

14. MOTHER'S MAIDEN NAME

Mary L. West

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War 2

16. SOCIAL
SECURITY NO.

248-053955

17. INFORMANT

Lottie M. Wilson

ADDRESS

1729 N. Broadway

18.

193.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Glioma of brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7-12-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 15, 1965

23C. NAME of CEMETERY or CREMATORY

Baltimore Natl. Cemetery

23D. LOCATION

(City, town, or county)

(State)

5501 Fredrick Ave. Md

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

Robert E. Finken, M.D.

24C. FUNERAL DIRECTOR

Zyrrah T. Elickson 1129 N. Charles St

ADDRESS

F 620

65 7259		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7259	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				SAMUEL FARACE	
2. DATE AND HOUR PRONOUNCED DEAD		9 July 1965		9:45 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
B. COUNTY		Maryland			
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore		19-03	
D. STREET ADDRESS (If rural, give location)		304 S. Woodyear St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
male	caucasian	Married	May 11, 1921	44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tow Motor Operator		Trucking		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Farace		Delfonso			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
yes #2		212 12 0498		Mrs. Betty Jean Farace 304 S. Woodyear	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Craniocerebral injury DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB- UTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		truck yard		34 Thomas Ave. Balto 25 AACo MD	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
July 7, 1965 5:00 P.M.		WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		Trailer pulled from dock driver of tow motor which drove over edge of loading dock causing tow- motor and operator to fall to ground	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/>		and that on this basis, death in my opinion		motor and operator to fall to ground	
resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Charles S. Petty		7/10/65	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		July 14, 1965		Baltimore National Cem	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
JUL 13 1965		Robert E. Farley, M.D.		Thomas J. Kerry, Inc. 1600 Hollins St	
				ADDRESS	

Letter from M.E.'s office

8-4-65

M.H

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7260				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7260	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Sarah Gray				2. DATE AND HOUR OF DEATH 7/10/65 9:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-04			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1928 W. Mosher			
5. SEX Female	6. RACE N.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3/4/18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Derry Gray Sr.				14. MOTHER'S MAIDEN NAME Sarah Silver			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 119-18-8987		17. INFORMANT Derry Gray		ADDRESS 810 Dallas St.	
18. 445X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Malignant hypertension and Uremia DUE TO (B) Chronic Renal Failure DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/21 19 65 to 7/10 19 65, that (I) (we) last saw the deceased alive on 7/10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jonathan Tuerk				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/10/65	
23C. PHYSICIAN'S NAME (Type) Jonathan Tuerk				23D. ADDRESS M.D. University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-65		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR W.C. Morsch		ADDRESS 2800 North Ave	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 7261	
BIRTH NO. 65 7261		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. Dorothy E. Sneed		2. DATE AND HOUR OF DEATH July 11, 1965 9 ³⁰ PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		A. STATE MARYLAND B. COUNTY U.S.A. 27-10			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12			
		D. STREET ADDRESS (If rural, give location) 617 Winston Ave.			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Sept 24, 1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Snowhill, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown Liza Brittingham	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-1990		17. INFORMANT CHARLES J. SNEED	
				ADDRESS Above	
18. H2011 I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ARTERIOSCLEROTIC HEART DUE TO DISEASE & CORONARY ATHEROSCLEROSIS			
ANTECEDENT CAUSES		(B) ACUTE COLITIS, ETIOLOGY UNKNOWN			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) PULMONARY FIBROSIS - APEX probably PTB			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7-9 19 65 to 7-11 19 65 , that (1) (we) lost saw the deceased alive on 7-11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-12-65	
23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA, M.D.		23D. ADDRESS CHURCH HOME & Hosp. BALTO. 31, md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-15-65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
				24D. LOCATION (City, town, or county) (State) Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR R. B. E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd.	

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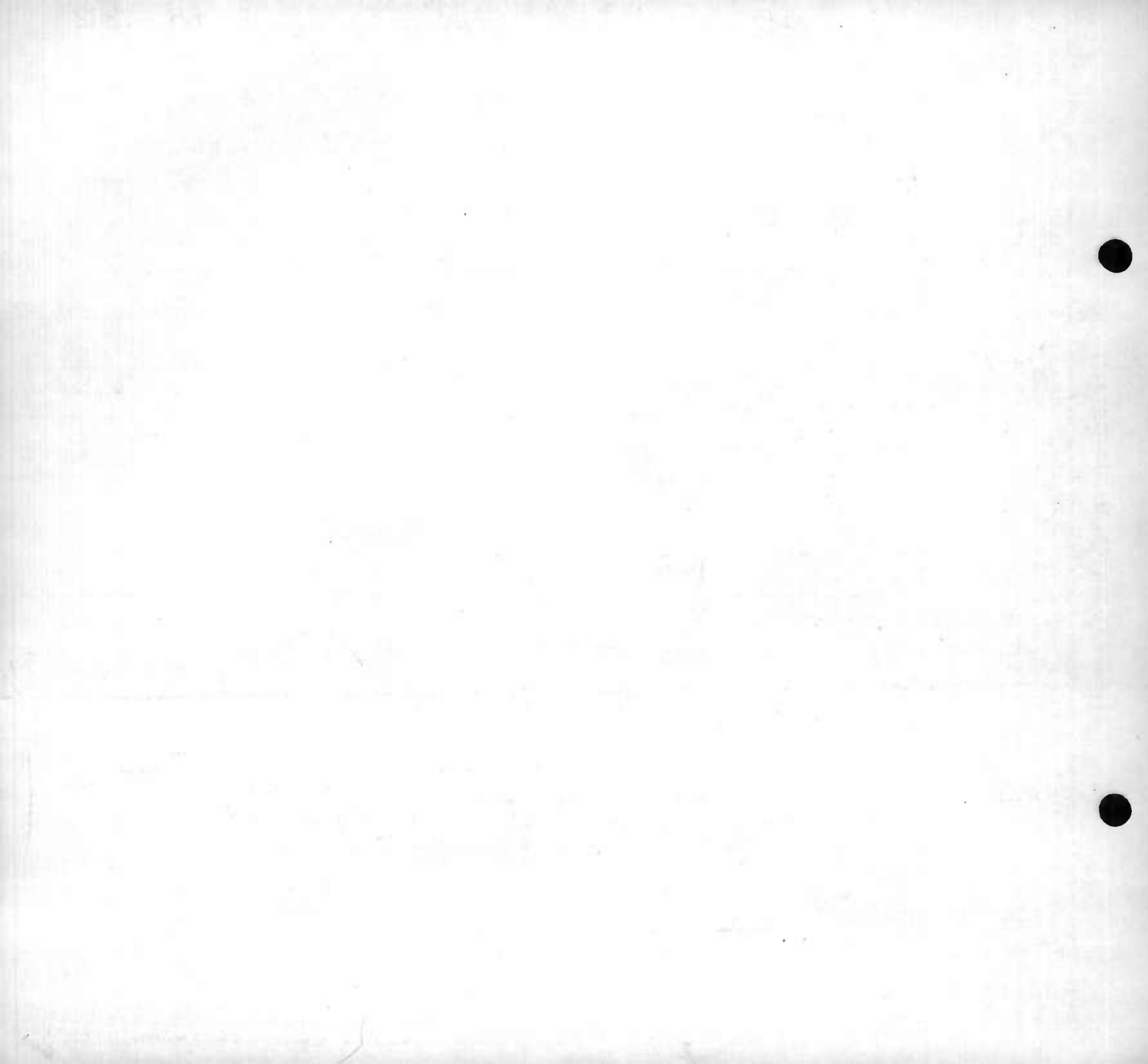
4. 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631,

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 7262		CERTIFICATE OF DEATH		Registered No. 65 7262	
1. NAME OF DECEASED (Type or Print) George EDWARDS				2. DATE AND HOUR OF DEATH JULY 13, 1965 6:20 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND LUTHERAN HOSPITAL OF MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 268 N. HILTON ST. NO. 29					
5. SEX F	6. RACE BLACK	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-16-1917? FEB. 16, 1914		9. AGE (In years last birthday) 48 yrs.		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prisoner in a drug/clean store			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? AMERICAN CITIZEN		
13. FATHER'S NAME LANE EDWARDS				14. MOTHER'S MAIDEN NAME MARY ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1963 SERGEANT			
16. SOCIAL SECURITY NO.				17. INFORMANT MRS. LOLA EDWARDS		ADDRESS 268 N. HILTON ST. NO. 29			
18. 150 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CARDIAC FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CARCINOMA OF THE ESOPHAGUS				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 1 19 65 to July 13 19 65 , that (I) (we) last saw the deceased alive on July 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. S. REROMA				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 13, 1965			
23C. PHYSICIAN'S NAME (Type) F. S. REROMA				23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-16-65		24C. NAME of CEMETERY or CREMATORY Balto. National		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR P. Warming		ADDRESS 72700 Elmwood Ave.			



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65 7263

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 7263

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BENNIE SUMPTER

2. DATE AND HOUR PRONOUNCED DEAD

7-11-65

4:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1100 Ashburton Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

2-28-1923

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgetown S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Willie Bryant

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

248-28-0095

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

E981X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) ~~XXXX~~

Multiple bullet wounds

With bilateral hemothorax

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Service Station

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2812 W Franklin Street

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

7

11

'65

4:03 PM

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

operator shot with 38 calibre revolver

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7-12-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-15-65

23C. NAME OF CEMETERY or CREMATORY

mt. Auburn

23D. LOCATION

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

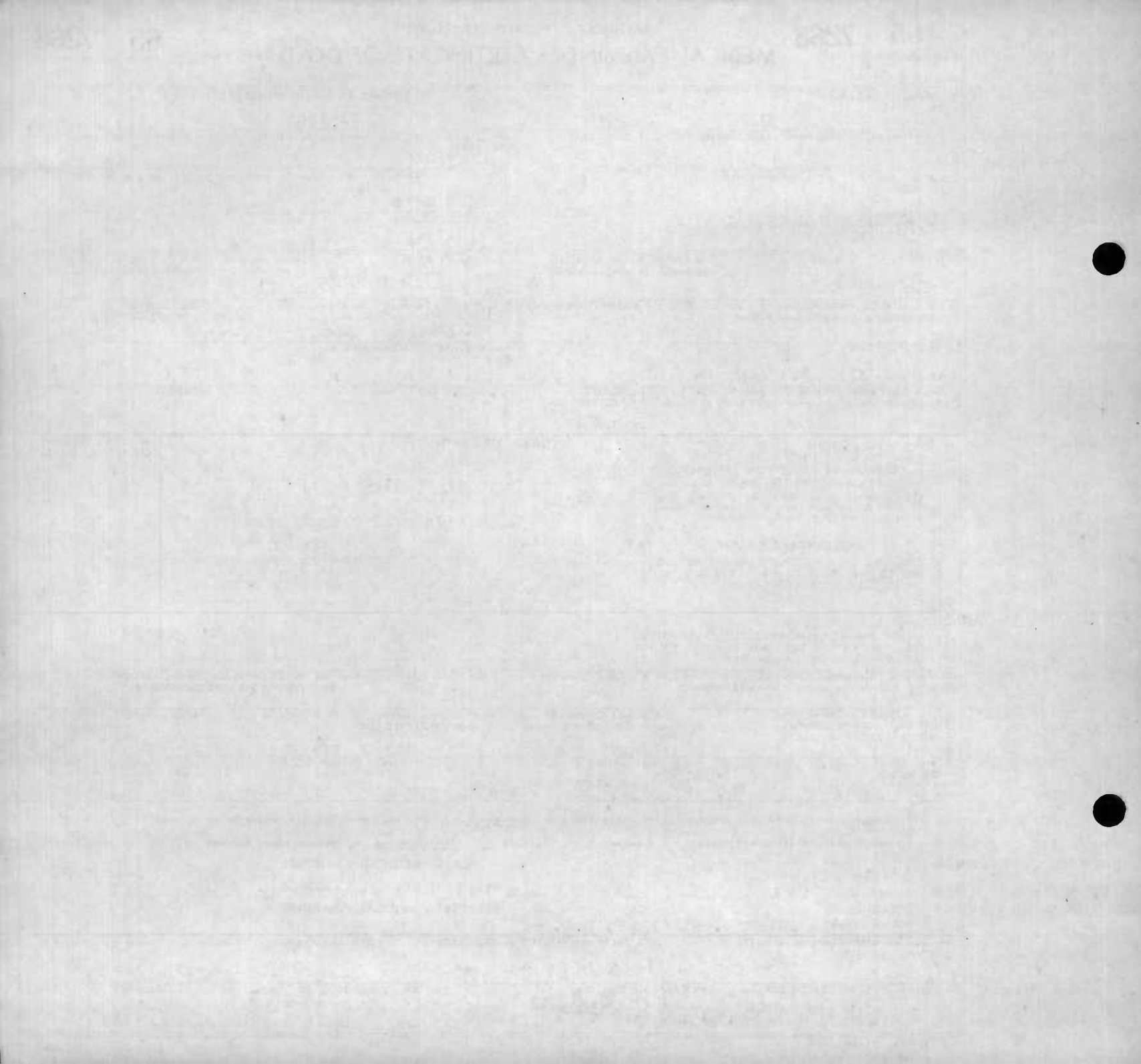
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

C. Wainwright

ADDRESS

2700 Edmondson Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7264		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7264	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		ROBERTA DOUGLAS REA		2. DATE AND HOUR OF DEATH July 12, 1965 2.00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		27-48	
1028 Woodson Rd. Apt. "D"		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21212	
D. STREET ADDRESS (If rural, give location)		1028 Woodson Rd. Apt. "D"			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
female	white	widowed	Dec. 15, 1884	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Phillip C. Payne		Florence Jones		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		579-01-5028-D		Mrs. W. Gibbs McKenney (Daughter) 102 Estes Rd. Baltimore Md. 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X 260X		(A) Cerebro-vascular accident		Sudden.	
ANTECEDENT CAUSES		(B) Hypertensive arteriosclerotic cardiovascular disease		About 20 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes mellitus		About 5 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/22/1961 to 7/12/1965 and that (I) (we) last saw the deceased alive on 4/7/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Edwin B. Jarrett		7/13/1965.			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Edwin B. Jarrett		11 E. Chase St. Baltimore Md. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		July 15, 1965		Fort Lincoln Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 13 1965		A. E. Farley		HENRY SANDER & SONS, INC. Baltimore Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7265				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 7265	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Michael Cherry</i>				2. DATE AND HOUR OF DEATH <i>7.11.65 6:55 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD.</i>		B. COUNTY <i>Balto</i>	
C. CITY OR TOWN <i>Baltimore</i>		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS <i>6206 Liberty Rd. Terrace</i>		(If rural, give location)	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>9.26.89</i>	9. AGE (In years last birthday) <i>75</i>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>?</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Cherry</i>				14. MOTHER'S MAIDEN NAME <i>Rose Mayewski</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>717-05-5813</i>		17. INFORMANT <i>Hospital Chart</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.19204.0</i>		CAUSE OF DEATH <i>Acute M.I.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>ASCVD</i>		(B) DUE TO		(C) DUE TO	
ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Chronic Lymphocyte Leukemia</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>7.9.65</i> to <i>7.11.65</i> that (I) (we) last saw the deceased alive on <i>7.11.19.65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7.11.65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-15-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>HOLY RISARY CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE Co. MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>JOHN M. WEBER & SONS, INC.</i>		ADDRESS <i>401 S. CHESTER ST</i>	

Grand General Hospital
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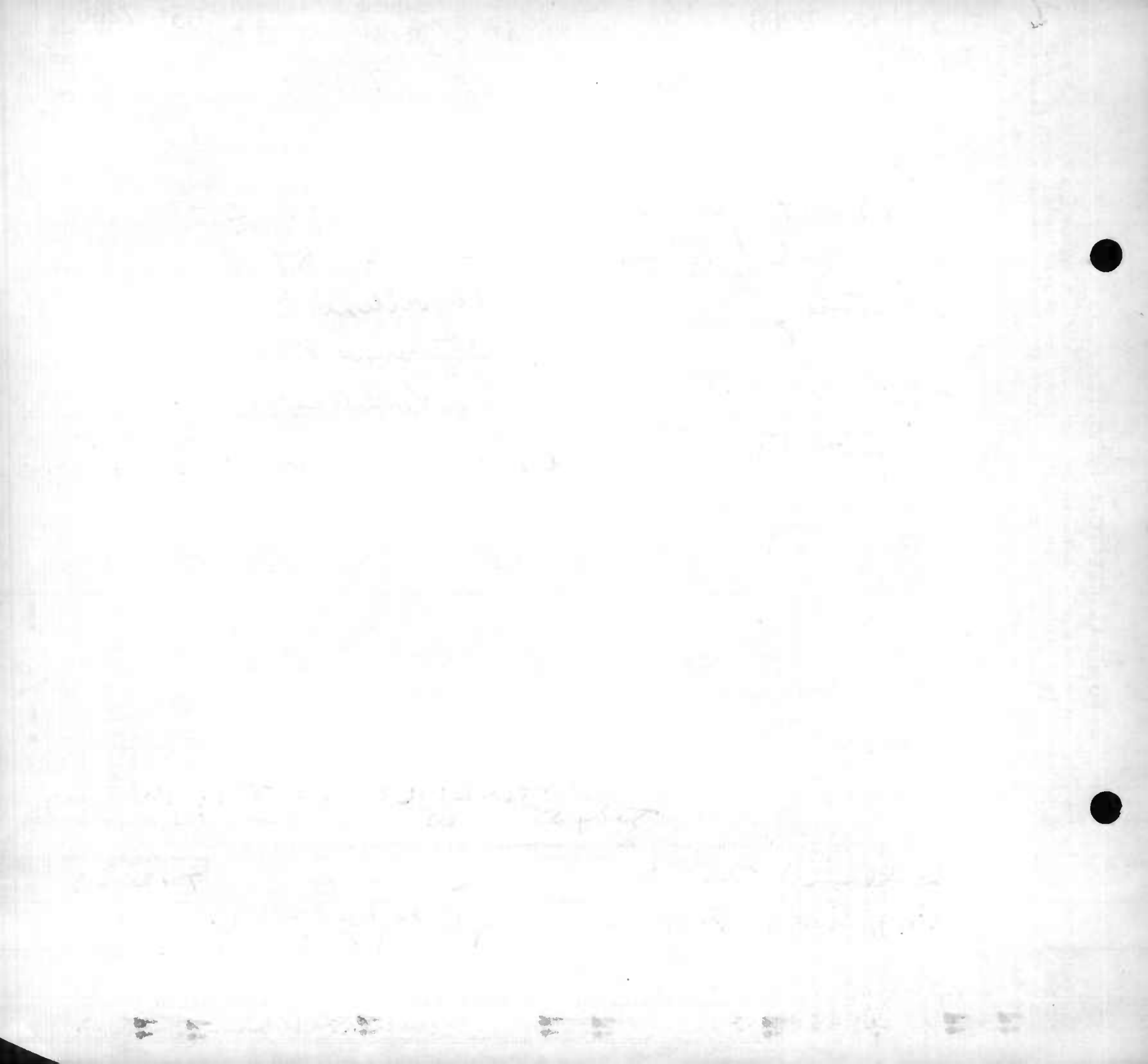
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

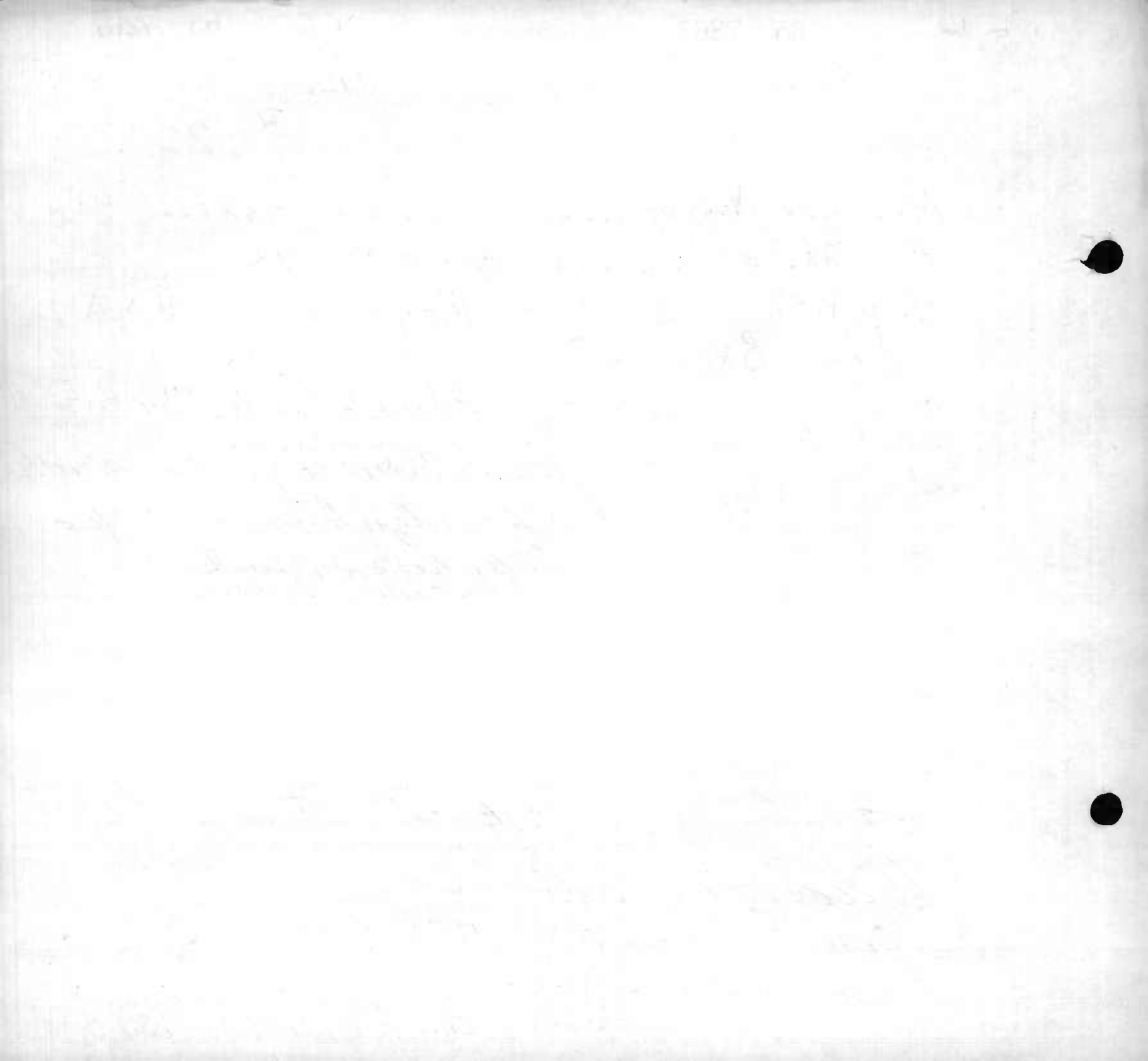
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 7266		Registered No. 65 7266	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Christina Bradley</i>				2. DATE AND HOUR OF DEATH <i>7-10-65 2:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Zion Hill Nursing Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>md</i>		B. COUNTY <i>17-01</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>411 George St</i>			
5. SEX <i>Fe</i>	6. RACE <i>Col</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i>	8. DATE OF BIRTH <i>3-8-1876</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			11. BIRTHPLACE (State or foreign country) <i>Abyville, S. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>?</i>			14. MOTHER'S MAIDEN NAME <i>Catharine Bradley</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Rosa Verdell - 523 W 157th St N. Y. C.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Candida vasc. for disease unknown</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>JAN 2, 1963</i> to <i>103 JULY 10 1965</i> , that (I) (we) last saw the deceased alive on <i>JULY 5 1965</i> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W. H. H. H. H.</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-12-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>W. H. H. H. H.</i>				23D. ADDRESS <i>1514 S. ...</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-13-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>mt Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Gurnett's ...</i>		ADDRESS <i>Balto. md</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 7267		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 7267	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sadie F. Franke		2. DATE AND HOUR OF DEATH July 7 1965 4 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION Melchor Nursing Home		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cub Hill 53-00	
		D. STREET ADDRESS (If rural, give location) 9944 HARFORD RD			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH April 13-1873	9. AGE (in years last birthday) 92	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Brewster		14. MOTHER'S MAIDEN NAME Briton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Edward L. Franke 9944 Harford Rd	
18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Dehydration & Decomposition 1 month		CAUSE OF DEATH (A) DUE TO Generalized Arterio - 10 yrs (B) DUE TO Sclerotic Cardio Renal Vascular Disease (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/2 1965 to 7/7 1965 , that (I) last saw the deceased alive on 7/6 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chas. F. O'Donnell		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Chas. F. O'Donnell		23D. ADDRESS 7501 YORK RD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/10/65		24C. NAME of CEMETERY or CREMATORY Parkwood	
				24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Chas. F. Evans & Son 8802 Harford Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 7268					CERTIFICATE OF DEATH		Registered No. 65 7268		
1. NAME OF DECEASED (Type or Print) FLORENCE E. THOMAS					2. DATE AND HOUR OF DEATH 7-12-65 5:05 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL					A. STATE 8. COUNTY MARYLAND 16-03				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 627 W. MOUNT ST.				
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-10-11	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME WALTER CORNISH				14. MOTHER'S MAIDEN NAME SADIE Jiles					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS same	
18. 434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pulmonary hemorrhage DUE TO (B) ? Pulm. Emboli DUE TO (C) Congestive ht failure + ? Mitral stenosis				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1-2 wks 10 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No; not performed as yet	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 7/5 1965 to 7/12 1965, that (I) (we) last saw the deceased alive on 7/12 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert I. Keimowitz M.D.					23B. DATE SIGNED 7/12				
23C. PHYSICIAN'S NAME (Type) Robert I. Keimowitz M.D.					23D. ADDRESS Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-16-65		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem			24D. LOCATION (City, town, or county) (State) A.A.Co. Md		
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.			25C. FUNERAL DIRECTOR Sullivan Funeral Home - N. Arlington Ave			ADDRESS 1011-13	

11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847

1. The first group of people who are interested in the study of the history of the United States are the people who are interested in the history of the United States.

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517

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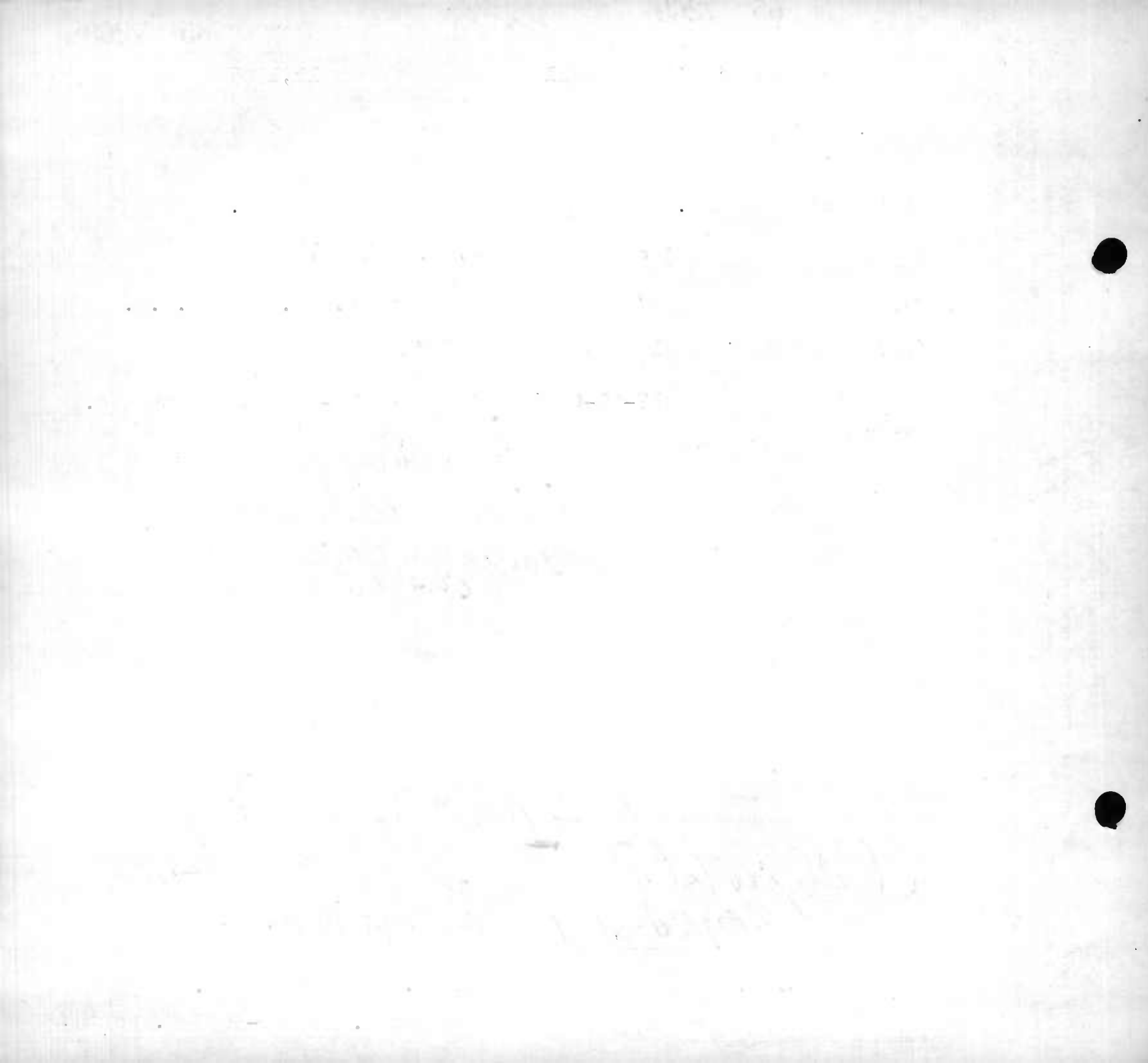
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27. 1952. E. 1952/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

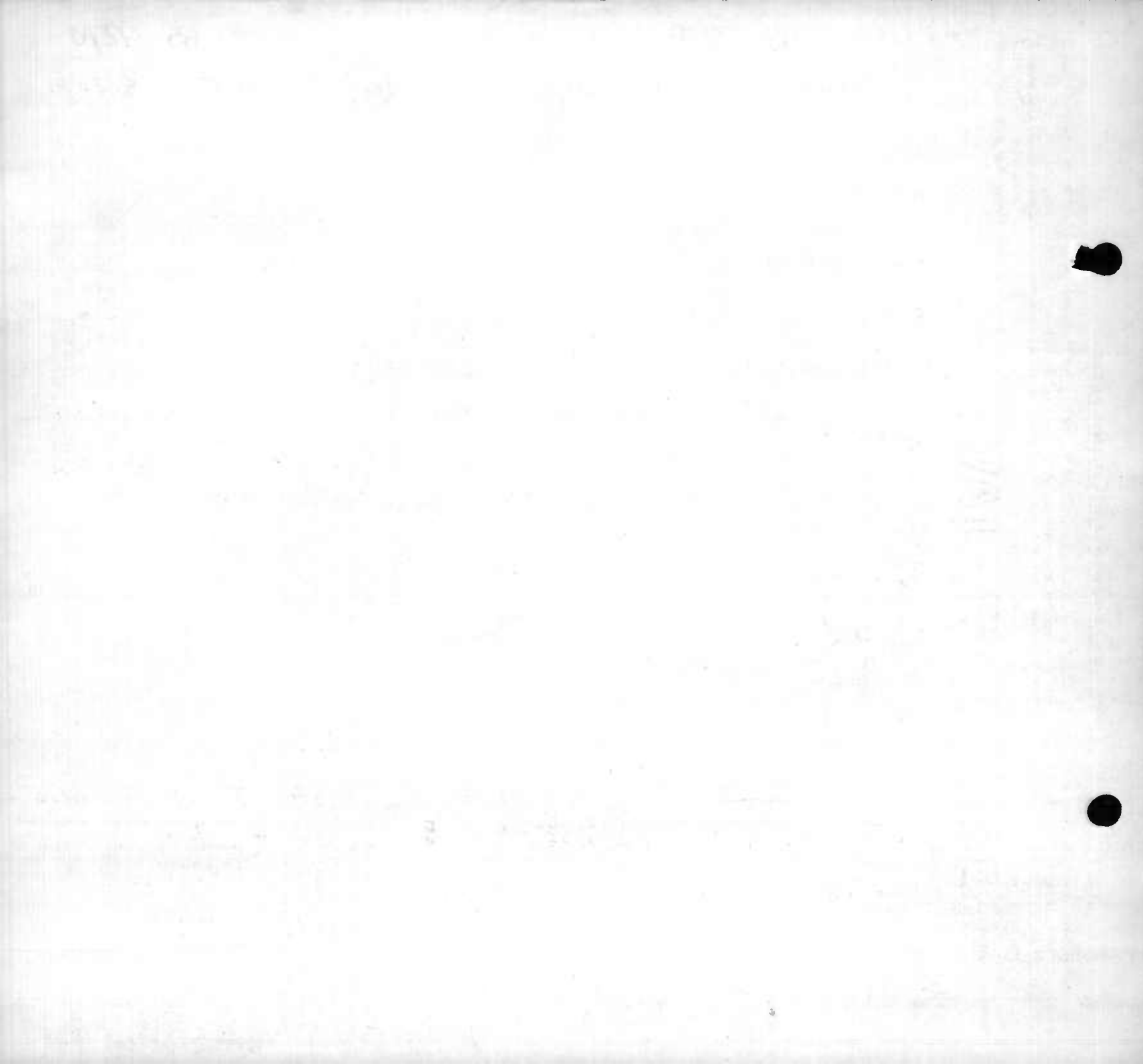
| BIRTH NO. 65 7269 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7269 | |
|--|---------------------------|--|---------------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Edward William Randall | | | | 2. DATE AND HOUR OF DEATH
July 11, 1965 10:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY
28-02 | |
| 00 5303 Bosworth Ave. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 5303 Bosworth Ave. | | | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
10/26/1887 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY
Waterfront | | 11. BIRTHPLACE (State or foreign country)
New Kent Co. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Edward Randall | | | | 14. MOTHER'S MAIDEN NAME
Mollie ? ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-01-0802 | | 17. INFORMANT
Alma Randall-5303 Bosworth Ave. | | ADDRESS | |
| 18. 442X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Respiratory failure | | CAUSE OF DEATH
(A) DUE TO
Myocardial Insufficiency | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Arteriosclerotic Cardiovascular disease | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/12/65 19 to July 11 19 65 , that (I) (we) last saw the deceased alive on 10/12/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
L. Shorofsky | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/13/65 | |
| 23C. PHYSICIAN'S NAME (Type)
L. Shorofsky | | M.D. | | 23D. ADDRESS
6014 Monroe Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/15/65 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Pk. | | 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Faldut | | 25C. FUNERAL DIRECTOR
Herbert E. Nutter-3035 W. North Ave | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

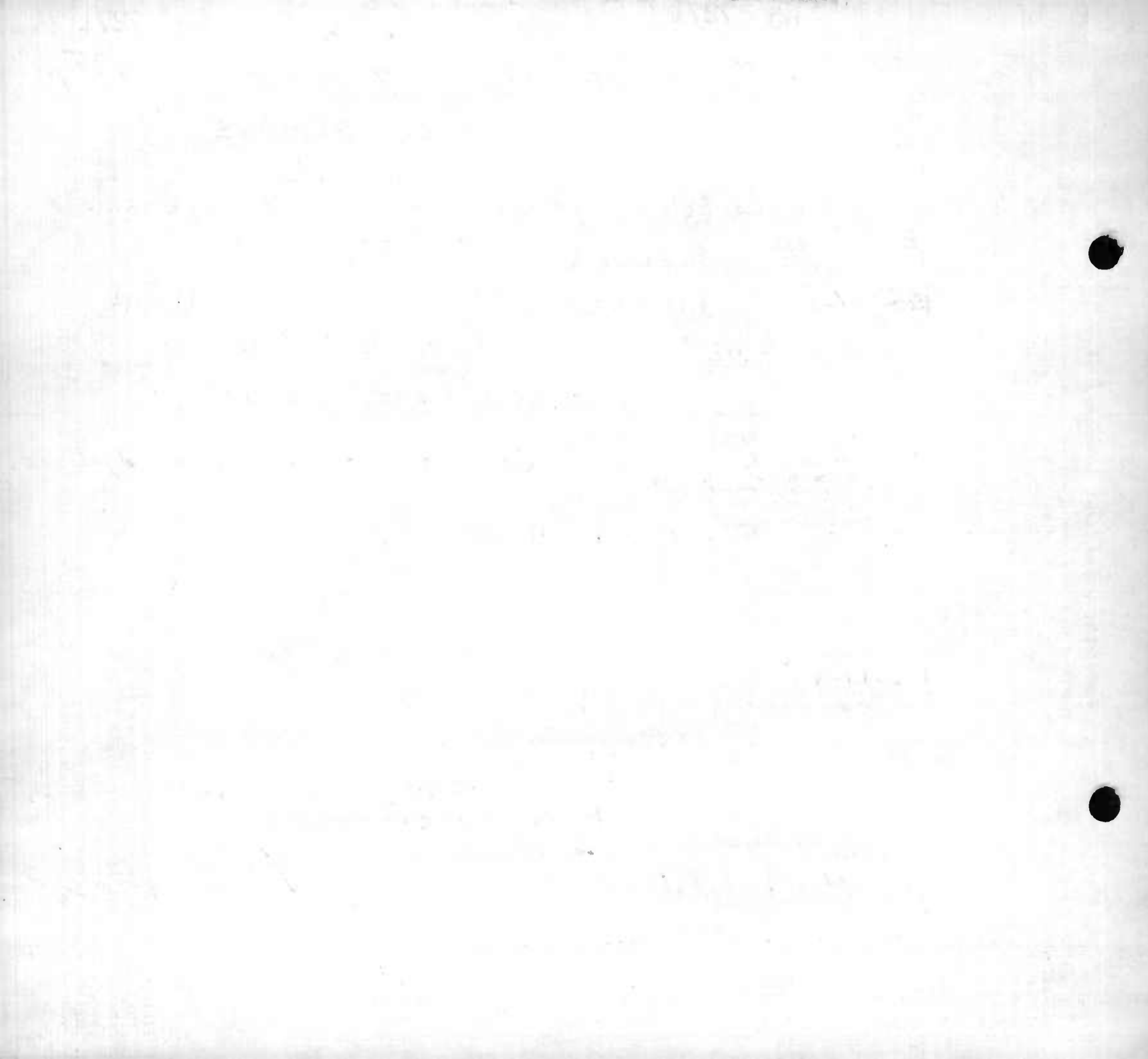
| BIRTH NO. 65 7270 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7270 | |
|--|---------------|--|-------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) DAVID MORRIS MILLET | | | |
| 2. DATE AND HOUR OF DEATH | | | | JULY 8, 1965 8.30 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 27-20 | |
| 20 3310 CLARKS LANE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3310 CLARKS LANE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH AUG 12, 1896 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET | | 10B. KIND OF BUSINESS OR INDUSTRY GROCER | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME MORRIS | | | | 14. MOTHER'S MAIDEN NAME RACHAEL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-26-1474 | | 17. INFORMANT WIFE | | ADDRESS 3310 CLARKS LANE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO Myocardial infarction | | 8 years | |
| ANTECEDENT CAUSES | | | | (B) DUE TO Coronary Atherosclerosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | None | | | |
| 19A. DATE OF OPERATION 0 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-8 1954 to 7-8 1965, that (I) (we) last saw the deceased alive on 7-8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Fern Aslman | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7-8-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7/9/1965 | | 24C. NAME of CEMETERY or CREMATORY HERRING RUN | | 24D. LOCATION (City, town, or county) (State) BALTO. MD | |
| 25A. DATE REQUIRED BY HEALTH DEPT. JUL 13 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC. | | ADDRESS 3319 OLYMPIA AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|-------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7271 | |
| BIRTH NO. 65 7271 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 7-10-65 9³⁵ P. M. | |
| 1. NAME OF DECEASED
(Type or Print) Gertrude M. Randle | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Hospital for the Women of Maryland
(If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Cockeysville
D. STREET ADDRESS (If rural, give location)
Masonic Home, Bonnie Blink | |
| 5. SEX F | 6. RACE W. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
3-3-1892 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BOOKKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY
ACCOUNTING | 9. AGE (In years last birthday) 73 |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Smith | | 14. MOTHER'S MAIDEN NAME
Gertrude Anders | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
247-03-5716 | 17. INFORMANT
Patients' Chart |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
1533 I | | CAUSE OF DEATH
Carcinomatosis (Ca. Sigmoid)-2 mo. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
6-14-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) ✓ | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-30 1965 to 7-10 1965 , that (I) (we) last saw the deceased alive on 7-10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Loures F. Tabotabo
M.D. | | 23B. DATE SIGNED
7-10-65 | |
| 23C. PHYSICIAN'S NAME (Type)
LOURES F. TABOTABO
M.D. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
JUL 13 1965 | |
| 24C. NAME of CEMETERY or CREMATORY
LODGE PARK | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR
WM. COOK-BROOKS | | ADDRESS
1050 YORK ROAD TOWSON, MD 21204 | |



FUNERAL DIRECTOR: IMPORTANT

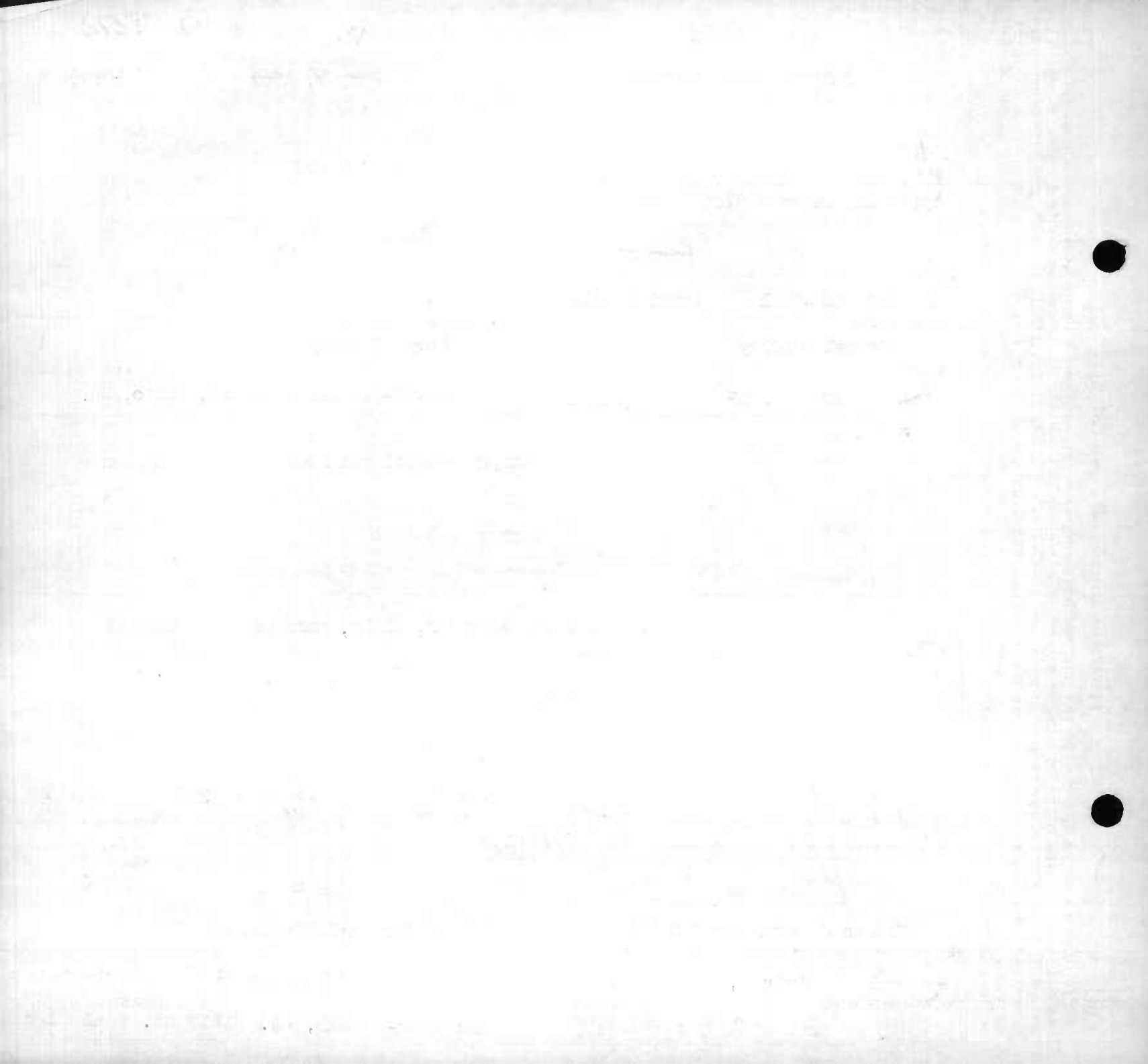
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------------------|--|--|--|------------------------------------|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 7272 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 7272 | | | | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) GARLAND MOORE DOUGHTY | | | | | 2. DATE AND HOUR OF DEATH
July 7, 1965 10:30 A.M. | | | | | | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Va. B. COUNTY V-43 | | | | | | | | | | | | | | | | | | | |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | | | 6. CITY OR TOWN (If outside city limits, write RURAL and give township)
Willis Wharf | | | | | 7. STREET ADDRESS (If rural, give location)
Box 93 | | | | | | | | | | | | | | |
| 5. SEX
M | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
5/25/86 | | 9. AGE (In years last birthday)
79 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired - BM 1 | | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Coast Guardsman | | | | | 11. BIRTHPLACE (State or foreign country)
Va. | | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | |
| 13. FATHER'S NAME
Samuel Doughty | | | | | 14. MOTHER'S MAIDEN NAME
Mary Doughty | | | | | | | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes CG 1933 | | | | | 16. SOCIAL SECURITY NO.
231-36-9774 | | | | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | (A) Staphylococcal pneumonia
DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | | | | | | | |
| | | | | | | | | | | (B) _____
DUE TO | | | | | | | | | | | | | | |
| | | | | | | | | | | (C) _____
DUE TO | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No)
yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 20 19 65 to July 7 19 65 , that (I) (we) lost saw the deceased alive on July 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE
<i>Thomas J. Lau</i> | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED
7/7/65 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | | | | | | | | | M.D. 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | | | | 24B. DATE
July 7, 65 | | | | | 24C. NAME of CEMETERY or CREMATORY
Belle Haven Cemetery | | | | | 24D. LOCATION (City, town, or county) (State)
Belle Haven Virginia | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | | | | 25B. NAME OF REGISTRAR
<i>Robert E. Farber, M.D.</i> | | | | | 25C. FUNERAL DIRECTOR
Wm Cook-Brooks, Inc. | | | | | ADDRESS
1217 St. Paul Street | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7273 | |
|--|--------------------------------|--|--|--|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 7273 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>PETTUS, HARVEL</u> | | | 2. DATE AND HOUR OF DEATH
<u>7-8-65 2²⁰ p.m.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>MERCY HOSPITAL INC.</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>MD.</u> 8. COUNTY <u>4-D</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE CITY</u>
D. STREET ADDRESS (If rural, give location)
<u>606 E. BALTIMORE ST.</u> | | |
| 5. SEX
<u>MALE</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>1-16-15</u> | 9. AGE (In years last birthday)
<u>50</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CRANE OPERATOR</u> | | | 11. BIRTHPLACE (State or foreign country)
<u>ALABAMA</u> | | |
| 13. FATHER'S NAME
<u>OSCAR S. PETTUS</u> | | | 14. MOTHER'S MAIDEN NAME
<u>ELIZABETH</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
ADDRESS
<u>Gray-Brown Mortuary Anniston, ALA.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>ANT. MYOCARDIAL INF.</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>approx. 24h</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>C. ARTERIOSCLEROTIC C.V.D.S.</u> | | | CAUSE OF DEATH
(A) DUE TO <u>ANT. MYOCARDIAL INF.</u>
(C) <u>UNKNOWN</u> | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Tuberculosis, advanced</u> | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-8 1⁴⁵am 1965</u> to <u>7-8 2²⁰pm 1965</u> , that (I) (we) last saw the deceased alive on <u>7-8 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Mary Jim Ratner</u> | | | | 23B. DATE SIGNED
<u>7-9-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>TRANSIT</u> | | 24B. DATE
<u>7-10-65</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>ANNISTON, ALABAMA</u> | |
| 25A. DATE REC'D. BY HEALTH DEPT.
<u>JUL 13 1965</u> | | 25B. NAME OF REGISTRAR
<u>John O. Mitchell</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>JOHN O. MITCHELL & SONS, INC.</u>
<u>1900 EUTAW PLACE BALTO, MD.</u> | |

10-10-12

10-10-12

MISS WHITE MARRIED 1-14-12
HEAVY HOSPITAL INC
BALTIMORE CITY
10-10-12

ANT HYOCARDIAL THE XRAY
C. ANTENNAE ROTIC CYD
~~XXXXXXXXXX~~

XXXXXXXXXX
YES YES

1-10-12

1-10-12

MISS JANE GATHER

X

1-10-12

MISS JANE GATHER

65 7274

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 7274

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

KATHERINE. GREENFIELD

2. DATE AND HOUR PRONOUNCED DEAD

10 July 1965

12:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1534 Light St.

5. SEX

female

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12/5/1879

9. AGE (In years
last birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Dale Jarvis Arlington, Va.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/13/65

23C. NAME of CEMETERY or CREMATORY

Glen Haven Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Baltimore (Glen Burnie) Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC 715 Light St.

WALLLEY FORGE

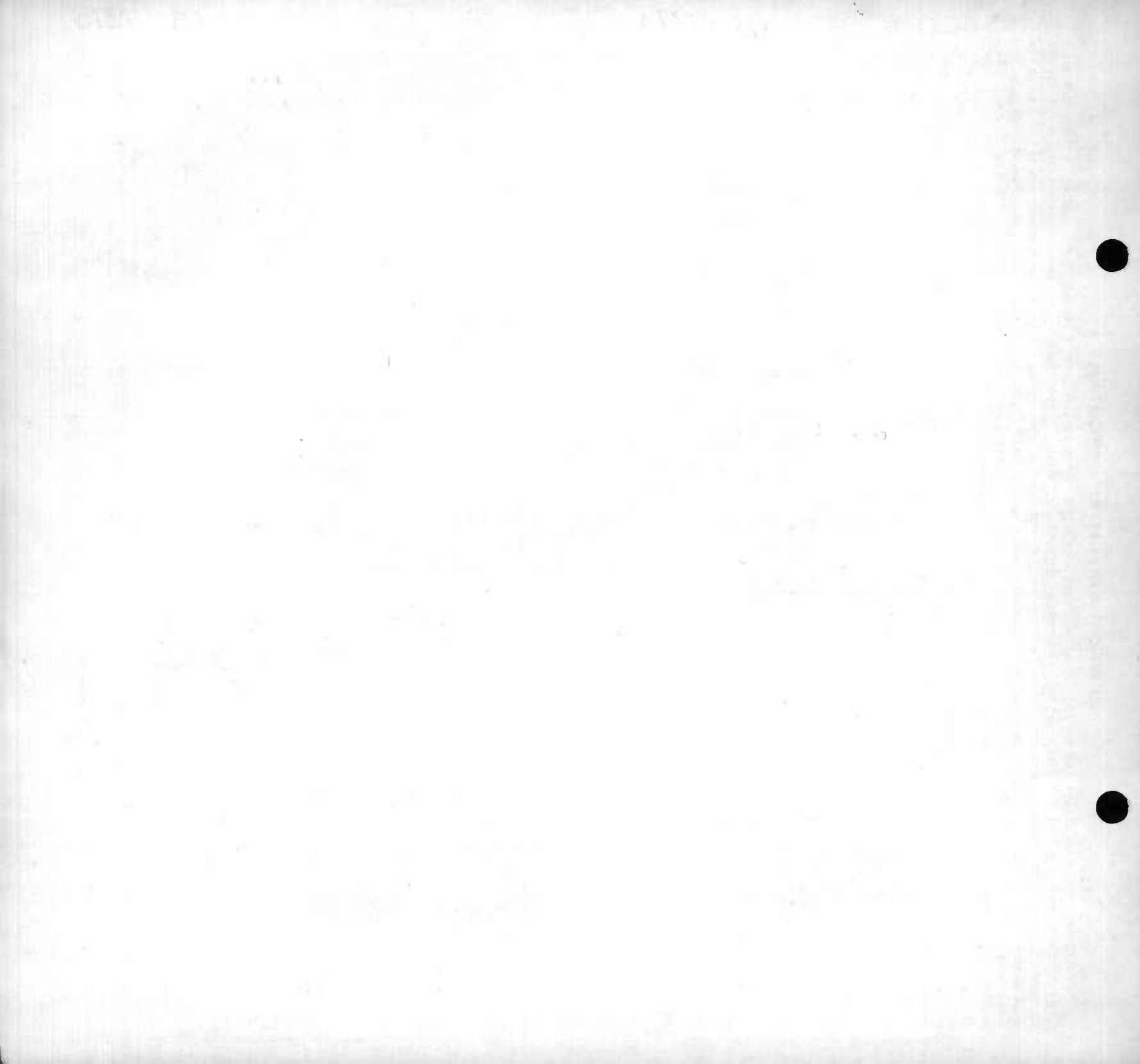
410 CONTENT

Chadwick 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

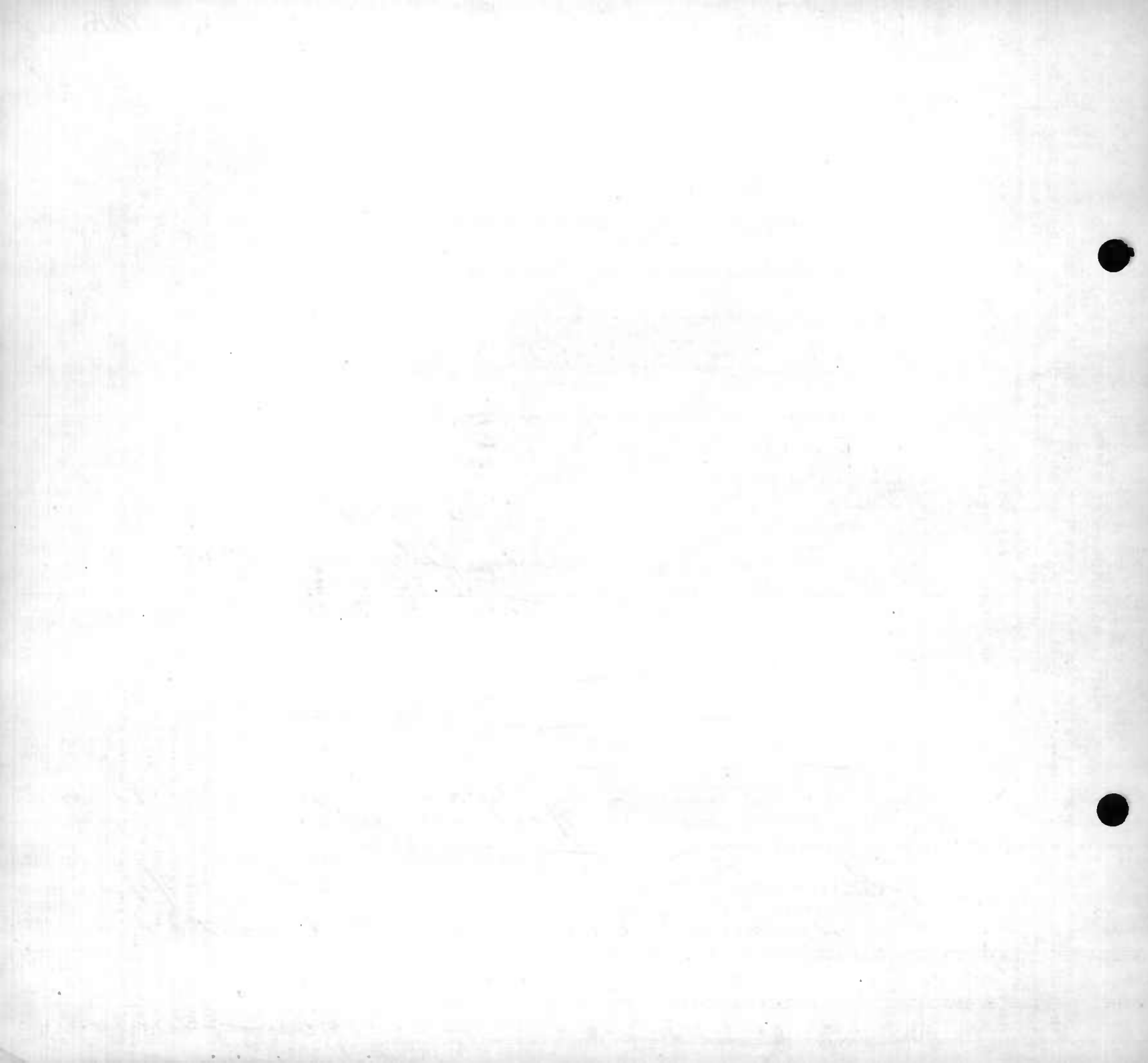
| BIRTH NO. 65 16835 65 7275 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7275 | | 4 | |
|--|--|--|--|---|--|---|--|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | M. | |
| (Type or Print) | | | | Baby Boy Williams | | 7/7/65 3:15 P | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give Township) | | BALTIMORE | |
| Johns Hopkins Hospital | | | | D. STREET ADDRESS (If rural, give location) | | 185 COLVIN STREET | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| Male | | Negro | | | | 7/7/65 | | 3 yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | JHH | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| XXXXXXXXXX | | | | GERALDINE, LONGS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 762.51 | | | | Primary + Secondary Apnea. Immediate | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | Prematurely (Bwt 670 gms) | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/7 1965 to 7/7 1965, that (I) (we) last saw the deceased alive on 7/7/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Russell S. Arnes | | | | 7/7/65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Russell S. Arnes | | | | JHH | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| CREMATION | | 7-9-56 | | JOHNS HOPKINS HOSPITAL | | BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUL 13 1965 | | Robert E. Fisher | | HOSPITAL DISPOSAL | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. <u>65-14543</u> | | 65 7276 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 7276</u> | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) <u>BABY GIRL MORAN</u> | | | |
| 2. DATE AND HOUR OF DEATH
<u>7/1/65</u> <u>3:15P</u> M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>The Hospital for the Women of Maryland</u> | | (If not in hospital or institution, give street address or location) | | A. STATE
<u>MD</u> | | B. COUNTY
<u>HOWARD</u> | |
| C. CITY OR TOWN
<u>Ellicott City</u> | | (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS
<u>RFD 4, Old Annapolis Rd.</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. RACE
<u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>newborn</u> | | 8. DATE OF BIRTH
<u>6-30-65</u> | |
| 9. AGE (In years lost birthday) | | 10. AGE (In years lost birthday) | | 11. BIRTHPLACE (State or foreign country)
<u>BALTO MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>20 38</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME
<u>Robert Ferdinand MORAN</u> | | 14. MOTHER'S MAIDEN NAME
<u>DORIS MAY HAUSWALD</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>admission sheet.</u> | | ADDRESS | |
| 18. <u>754.5</u> I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<u>Gastrointestinal Hemorrhage.</u> | | CAUSE OF DEATH
(A) DUE TO
<u>Stress Ulcer</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>20 min.</u> | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
<u>Cardiac failure Congestive Heart Disease</u> | | <u>18 hrs.</u> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Tubercy 17-18.</u> | | <u>Birth.</u> | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6/30/65</u> to <u>7/1/65</u> ; that (I) (we) last saw the deceased alive on <u>7/1/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Hammond J. Dugan</u> M.D. | | | | | | 23B. DATE SIGNED
<u>7/1/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Hammond J. Dugan</u> M.D. | | | | | | 23D. ADDRESS
<u>4409 Underwood Rd.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 24B. DATE
<u>7/6/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Womens Hospital</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 13 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR
<u>John E. Adams</u> | | ADDRESS
<u>Womens Hospital</u> | |
| VS 150-REV. 1/1/65 | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | M.E. CASE NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | | | |
|--|--|---------|--|---|--|------------------|--|---|--|----------------------------|--|--|--|--|--|
| 65 | | | | 7277 | | | | 65 | | | | 7277 | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | |
| Herbert, Frances | | | | | | | | July 10 1965 9.55P M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | | | | A. STATE B. COUNTY | | | | | | | |
| 41 St. Josephs Hospital | | | | | | | | Maryland Balto | | | | | | | |
| | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | |
| | | | | | | | | Baltimore#6 53-00 | | | | | | | |
| | | | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | | | |
| | | | | | | | | 120 Raspe Ave. | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| female | | white | | widowed | | 12-2-90 | | 74 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Homemaker | | | | Housewife | | | | Baltimore Md. | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Anthony Pfarr | | | | | | | | Margaret Schissler | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | None | | | | Mrs Mildred Moore | | | | 120 Raspe Avenue 6 | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | | |
| II | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | | | | | Yes | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7 19 65 to July 10 19 65, that (I) (we) last saw the deceased alive on July 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | | | 23B. DATE SIGNED | | | |
| Govinda Rao M.D. | | | | | | | | | | | | July 11, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | | | | | |
| Govinda Rao | | | | | | | | 1400 N. Caroline St. Baltimore 21213 Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | | | 7-14-1965 | | | | Baltimore Cemetery | | | | Baltimore Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| JUL 13 1965 | | | | Robert E. Farley, M.D. | | | | Lassahn Funeral Home 7401 Parkview Rd | | | | (36) | | | |

FUNERAL DIRECTOR: IMPORTANT

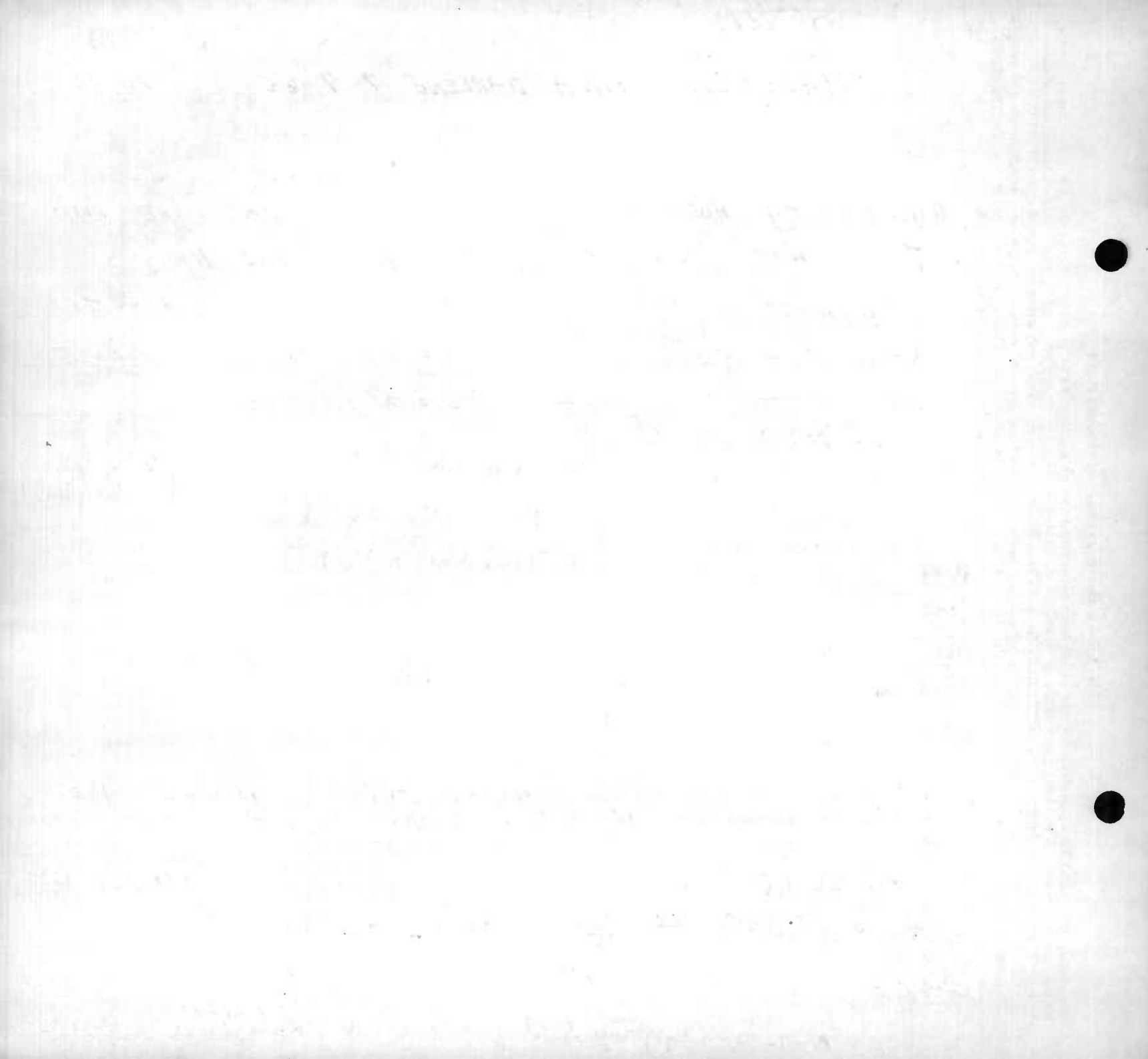
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7278 | |
|---|---------------------|--|--|---|---|
| BIRTH NO. 65 7278 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ARTHUR T. CANBY | | 2. DATE AND HOUR OF DEATH
JULY 9, 1965 10P | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD.
B. COUNTY 25-42 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2502 BROHAWN AVE 30 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 30 | | | |
| | | D. STREET ADDRESS (If rural, give location)
2502 BROHAWN AVE. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
OCT. 29, 1879 | 9. AGE (In years lost birthday)
85 | 10. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
UPHOLSTERING | | 10B. KIND OF BUSINESS OR INDUSTRY
RET. | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Charles J. Canby | | 14. MOTHER'S MAIDEN NAME
Zillah Fort | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ROBERT A. CANBY - 2502 Brohawn Ave | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) MURDER
DUE TO
(B) Generalized Arterio
DUE TO
(C) Cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH
3 day
6 wk
6 wks | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1 1965 to July 9 1965 , that (I) (we) last saw the deceased alive on July 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. yes | | | | | |
| 23A. SIGNATURE
Leo S M. Kieffer | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
July 12 65 | |
| 23C. PHYSICIAN'S NAME (Type)
LEO S M. KIEFFER | | M.D. | | 23D. ADDRESS
1010 Reede Ave Baltimore Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7/13/65 | | 24C. NAME OF CEMETERY or CREMATORY
LOUDON PARK | |
| 24D. LOCATION
BALTO. MD | | 24E. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 24F. NAME OF REGISTRAR
Robert E. Farkas | |
| 24G. FUNERAL DIRECTOR
MALNABE | | 24H. ADDRESS
301 FREDERICK RD | | 24I. 212 28 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

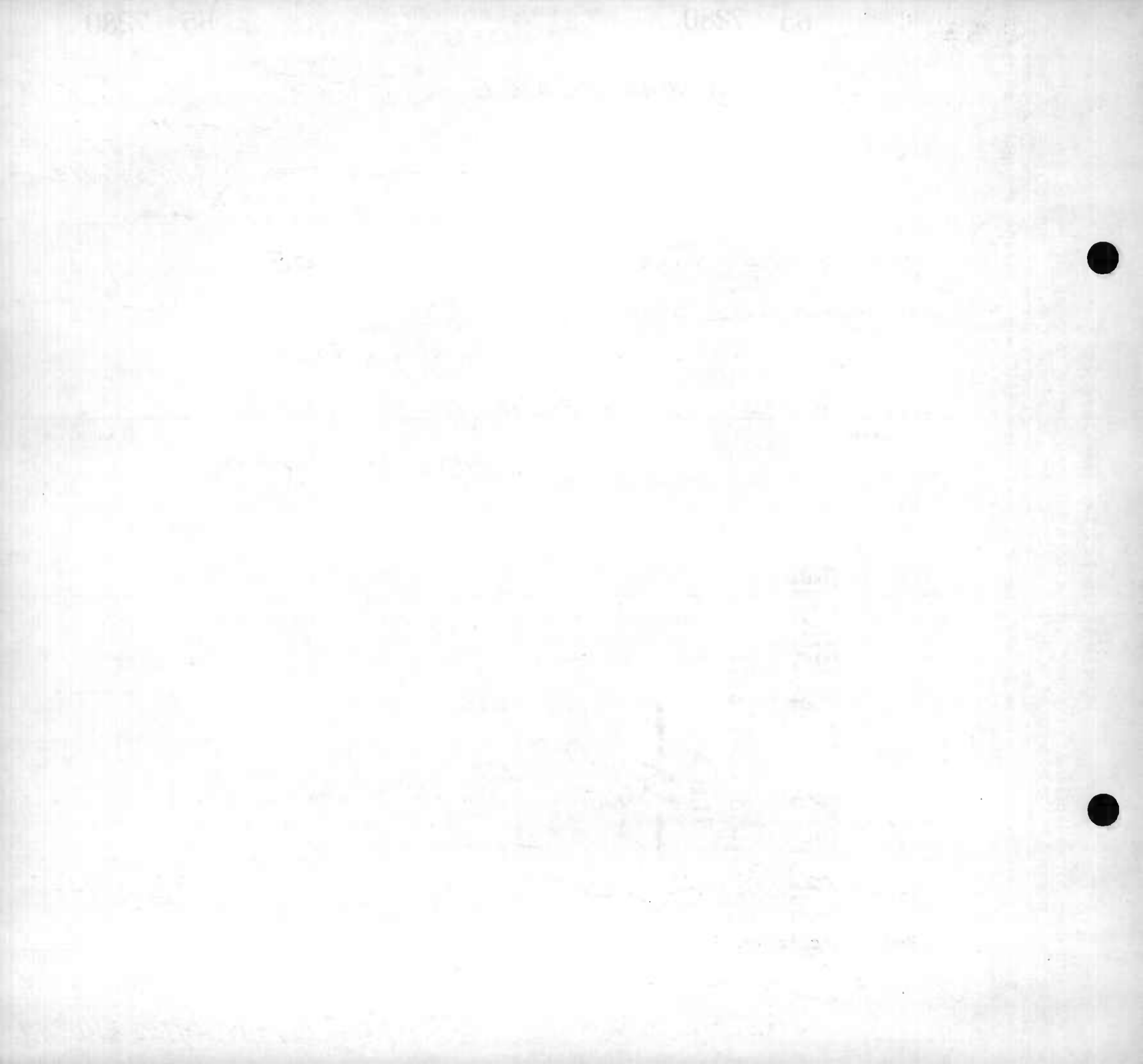
| BIRTH NO. | | | | M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
|--|--|---------|--|--|--|------------------------------------|--|---|--|---|--|--|--|--|--|
| 65 7279 | | | | H-420 | | | | HAUSLEE, TINA DARLENE | | | | 7-9-65 10:10 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | | | A. STATE B. COUNTY | | | | | | | |
| UNIVERSITY HOSPITAL | | | | | | | | MD. HOWARD | | | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | | | | SVKESVILLE 63-00 | | | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | RT. 3 SVKESVILLE, MD. | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| F | | WHITE | | SINGLE | | 8-9-64 | | 11 MO. 11 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| INFANT | | | | NONE | | | | MD. | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| KENNETH HAUSLEE (Haulsee) | | | | | | | | ELSIE THORPE - SAME | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| NO | | | | NONE | | | | Hospital Records | | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | | | | | CAUSE OF DEATH | | | | | | | |
| 473 X 1 | | | | | | | | SHOCK | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | Penicillin injection | | | | | | | |
| | | | | | | | | Tannin & U.R.I | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | | | | | NO | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7:30 p.m. 7/9/65 to 10:10 p.m. 7/9/65 that (I) (we) last saw the deceased alive on 10:5 p.m. 7/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | | | 23B. DATE SIGNED | | | |
| D. Abdul Latif | | | | | | | | | | | | 7/10/65 1:30 a.m. | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 23D. ADDRESS | | | |
| Dr. D.I. ABDUL-LATIF | | | | | | | | | | | | U. H. Box 199 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | | | 7-12-1965 | | Mt. Pleasant | | | | CARROLL Co. Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR'S ADDRESS | | | | | | | |
| JUL 13 1965 | | | | Robert E. Farber | | | | 3701 Wally Bldg 241 Sykesville, Md. | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7280 | |
|--|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 65 7280 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JAMES THOMAS CLARE | | 2. DATE AND HOUR OF DEATH
7-9-65 7 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 UNIV. OF MD. HOSPITAL | | A. STATE MD. B. COUNTY CARROLL 56-00 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Sykesville | | | |
| | | D. STREET ADDRESS (If rural, give location)
AND ANNA ROAD | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-3-09 | 9. AGE (In years last birthday)
55 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SHEET METAL WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY
BECK STEEL | | 11. BIRTHPLACE (State or foreign country)
MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JOHN CLARE | | 14. MOTHER'S MAIDEN NAME
LAURA FOSTER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES WWII | | 16. SOCIAL SECURITY NO.
214-03-6561 | | 17. INFORMANT ADDRESS
HOSPITAL CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
744.0 I Myasthenia Gravis | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from May 7 1965 to July 9 1965 that (X) (we) last saw the deceased alive on July 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Howard Witotzkey, Jr | | | | 23B. DATE SIGNED
9 July 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Howard Witotzkey, Jr | | | | 23D. ADDRESS
MD. | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
BURIAL | | 24B. DATE
7-12-65 | | 24C. NAME of CEMETERY or CREMATORY
Lake View Mem. Park | |
| 24D. LOCATION (City, town, or county) (State)
CARROLL Co. MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
C. M. Walz, Box 241, Sykesville Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

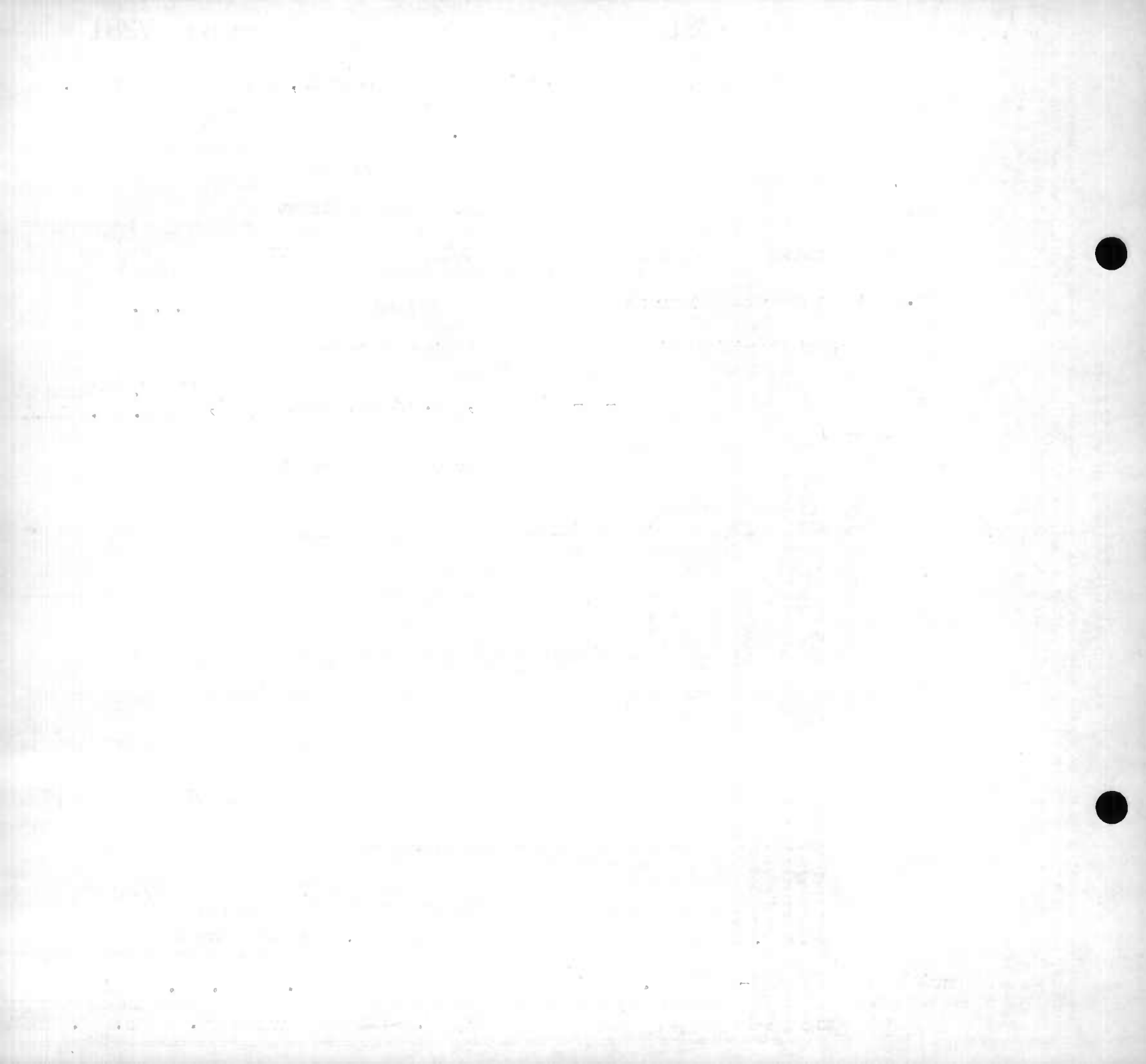
| BIRTH NO. | | 65 7281 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7281 | |
|--|---------|--|------------------|--|---------------------------------|--|--|
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| POTYRAJ, NORA (Honorata) | | | | July 10, 1965 2:05 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)

St. Joseph Hospital
41 | | | | A. STATE
Md. | | | |
| | | | | B. COUNTY
26-11 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 24 | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
3214 Elliott Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
lost birthday) | If Under 1 Yr.
Months: Days: | If Under 24 Hrs.
Hours: Min. | |
| Female | White | Widowed | 1/11/94 | 71 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ret. Haussner's Restaurant | | | | Poland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Antoni Wozniakowski | | | | Pauline Medinska | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | 217-01-0348 | | Son, Mr. Stanislaus Potyraj, 742 S. Potomac St. Balto. Md. 21224 | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Myocardial Infarction
DUE TO

(B) DUE TO

(C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 9 19 65 to July 10 19 65, that (I) (we) last saw the deceased alive on July 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Jose D. Manalo | | | | | | 7/10/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Jose D. Manalo | | | | 1400 N. Caroline Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | July 13-1965 | | St. Stanislaus | | Dundalk Ave. Balto. Md. 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | | |
| JUL 13 1965 | | Robert E. Fajana | | JOHN J. DUDA 2829 Hudson St. Balto. Md. 21224 | | | |



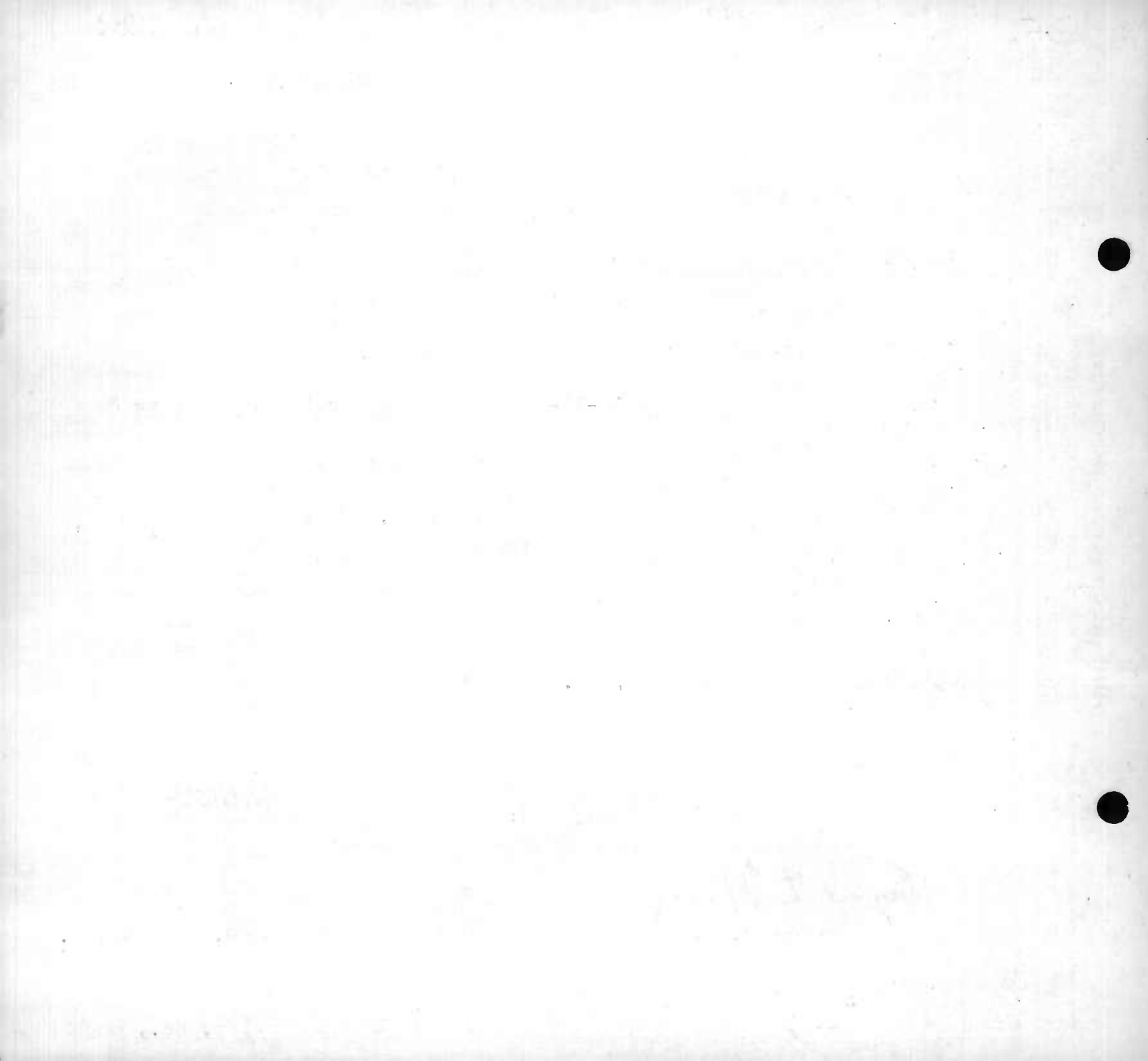
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7282 | |
|--|------------------|--|------------------------------|---|---|
| BIRTH NO. 65 7282 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ROSE (nmn) MARTINEZ | | 2. DATE AND HOUR OF DEATH
July 5th, 1965 12:45 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
80 6504 Colgate Avenue | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland 26-36
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 6504 Colgate Avenue | | | |
| 5. SEX
female | 6. RACE
white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
9/9/1909 | 9. AGE (In years last birthday)
55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Inspector | | 10B. KIND OF BUSINESS OR INDUSTRY
Steel | | 11. BIRTHPLACE (State or foreign country)
West Virginia | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
John Malagrín | | 14. MOTHER'S MAIDEN NAME
Lucy Tiano | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
216-10-9787 | | 17. INFORMANT
Anthony Martinez, same as #4 | |
| 18. 156.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (A) multiple hepatic metastasis
DUE TO
(B) adenocarcinoma, primary cause
DUE TO unknown
(C) | | INTERVAL BETWEEN ONSET AND DEATH
2 months | |
| 19A. DATE OF OPERATION
05/24/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
liver biopsy, exp. lap | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/5/65 19 to 7/5/65 19, that (I) (we) last saw the deceased alive on 7/5/65 11:30 pm and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Eugene F. Nevy | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/7/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Eugene F. Nevy | | 23D. ADDRESS
M.D. 7001 Mornington Road, Dundalk, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/9/65 | | 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Memorial | |
| 24D. LOCATION
Dorsey, Maryland | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Walter Brooks Bradley, Inc., Dundalk | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| BIRTH NO. <i>65-16714</i> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <i>65 7283</i> | | 9 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Baby Boy Prince</i> | | 2. DATE AND HOUR OF DEATH
<i>7/10/65 1:10 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Lutheran Hospital of Maryland</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Ind.</i> B. COUNTY <i>Balto</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Essex 53-00</i> | |
| D. STREET ADDRESS (If rural, give location)
<i>125 Randolph Rd.</i> | | 5. SEX <i>Male</i> | | 6. RACE <i>White</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| 8. DATE OF BIRTH <i>4/9/65</i> | | 9. AGE (in years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Francis M Prince</i> | | 14. MOTHER'S MAIDEN NAME
<i>Beulah M Harrell</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Parents</i> | | ADDRESS
<i>Above</i> | | 18. <i>760.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>Brain Damage</i> | | (B) <i>Respiratory distress syndrome</i> | | (C) | |
| INTERVAL BETWEEN ONSET AND DEATH | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>7/9/65</i> to <i>7/10/65</i> , that (I) (we) lost saw the deceased alive on <i>7/10/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
<i>Harold C. Colburn</i> | | 23B. DATE SIGNED
<i>7/10/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7/10/65</i> | |
| 24C. NAME OF CEMETERY or CREMATORY
<i>M. E. Kenny</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Bakersville N.C.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 13 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Johnson</i> | |
| 25C. FUNERAL DIRECTOR
<i>John J. Connelly</i> | | ADDRESS
<i>Essex 21 md</i> | | VS 150-REV. 1/1/65 | | | |

March 22 1892

4/10/92

Letter from Mr. [illegible]
and [illegible]

4/10/92

[illegible]

from [illegible]

report [illegible]

4/10/92

March 22 1892

4/10/92

4/10/92

65 7284

BALTIMORE CITY HEALTH DEPARTMENT

65 7284

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RITA INMAN

2. DATE AND HOUR PRONOUNCED DEAD

9 July 1965

7:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

9 Bluebird lane

5. SEX

female

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct 8 - 1919

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Rocco Corrado

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

283-24-7410

17. INFORMANT

Fred Inman

ADDRESS

Same

18.

443 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

7/10/65

23C. NAME of CEMETERY or CREMATORY

Forest Lawn

23D. LOCATION

(City, town, or county)

(State)

Youngstown Ohio

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Connelly Sons

ADDRESS

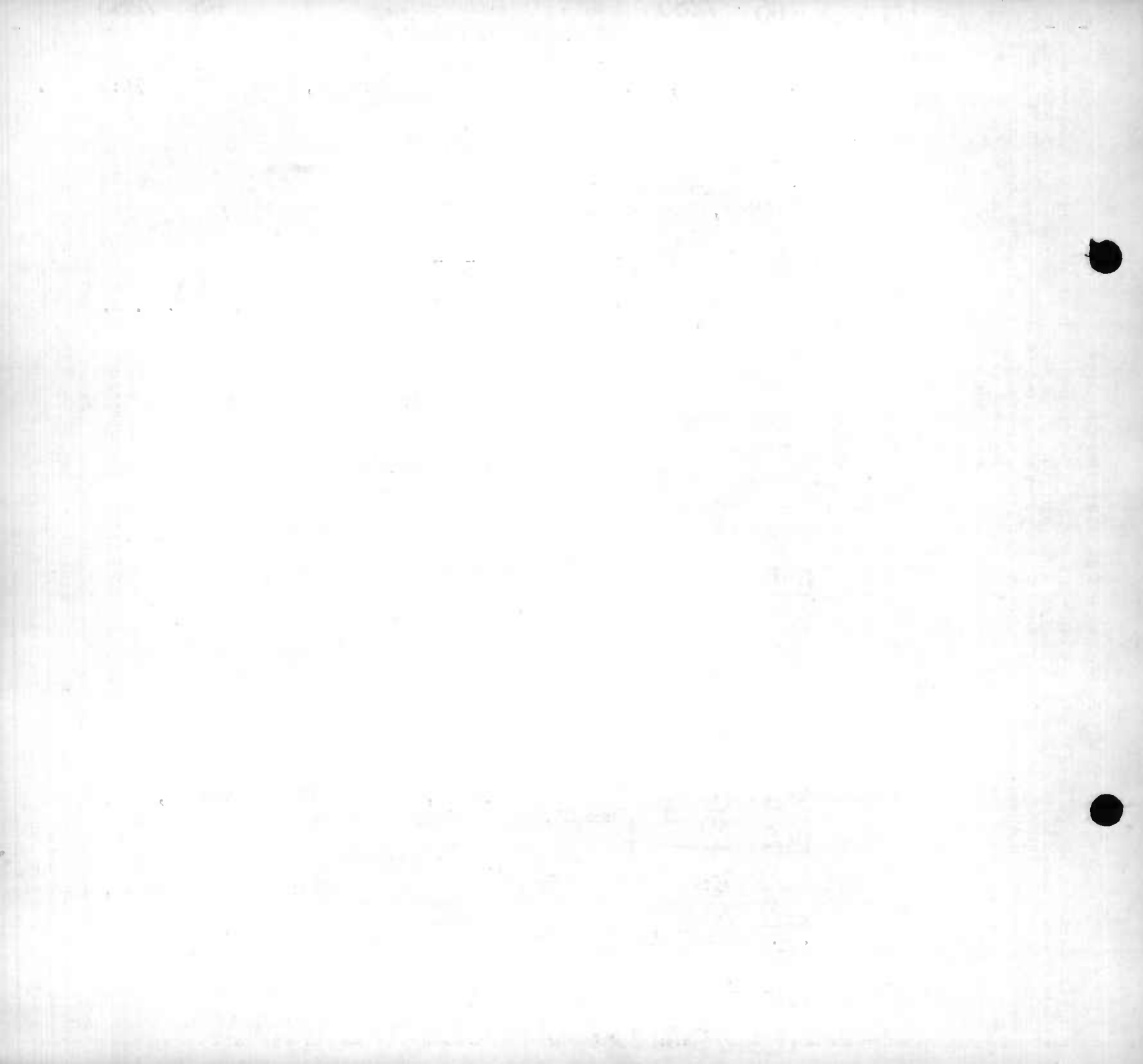
301 Race

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65-15049 65 7285 | | 65-15049 65 7285 | |
|---|--------------------------|---|--------------------------------------|---|---|--|--|
| BIRTH NO. 65-15049 65 7285 | | | | CERTIFICATE OF DEATH | | Registered No. _____ | |
| 1. NAME OF DECEASED
(Type or Print) Martin, Baby Girl, Flossie | | | | 2. DATE AND HOUR OF DEATH
June 25, 1965 10:10 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY 3-81
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
215 Ballou Court 21231 | | | |
| 5. SEX
Negro | 6. RACE
Female | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
6-25-1965 | | 9. AGE (In years last birthday)
5 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Severe Prematurity | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 25, 1965 to June 25, 1965 , that (I) (we) last saw the deceased alive on June 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
S. Wayne Klein | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
June 25, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. S. Wayne Klein | | | | 23D. ADDRESS
M.D. 4940 Eastern Avenue 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremated | | 24B. DATE
6-30-65 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore City Hospitals | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
HOSPITAL DISPOSAL | | | |



FUNERAL DIRECTOR: IMPORTANT

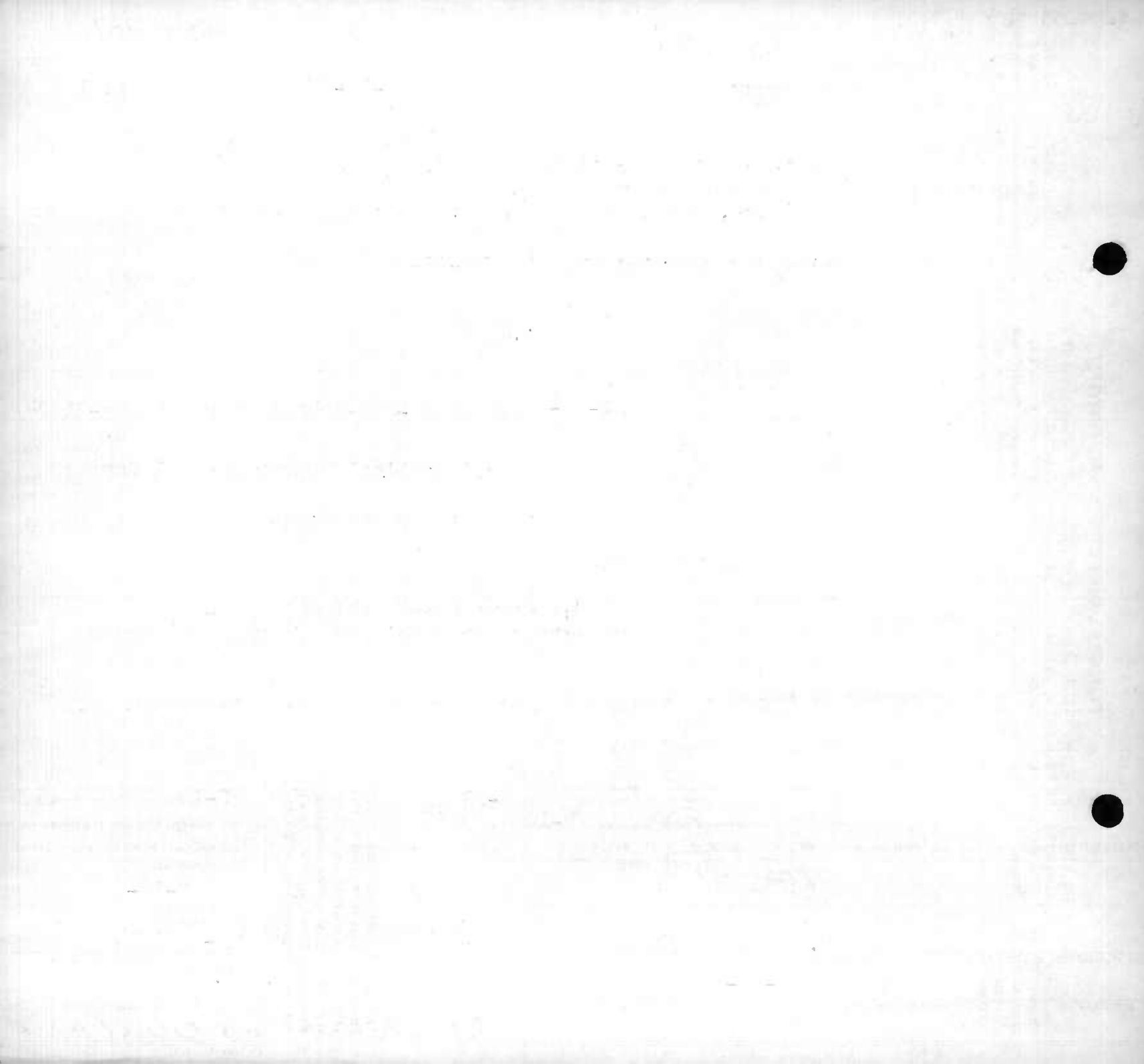
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7286 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 7286 | |
|---|---------------|--|-----------------------------|--|--|--|--|----------------------------------|--|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY FLORENCE SMITH | | | | 2. DATE AND HOUR OF DEATH 7-9-65 3:50PM M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) CALLAWAY ST. MARY'S COUNTY D. STREET ADDRESS (If rural, give location) 68-00 | | | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 10/27/1907 | | 9. AGE (In years lost birthday) 18 1/2 | 10. If Under 1 Yr. Months Days | | 11. If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Great Mills, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME ISAAC HILL | | | | 14. MOTHER'S MAIDEN NAME MARY BARBAR | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT James B. Jordan | | ADDRESS Drayden, Maryland | | | |
| 18. 443 X-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH Subarachnoid Hemorrhage, Hypertensive C.V.D. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | | | |
| | | | | (B) DUE TO | | | | | |
| | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Aneurysm Anterior Communicating Artery; Anemia and thrombocytopenia unknown etiology, probably myeloid metaplasia. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/3 19 65 to 7/9 19 65, that (I) (we) last saw the deceased alive on 7/9 19 65 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Lee J. Silver | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/9/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Lee J. Silver | | | | 23D. ADDRESS Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/12/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Face Cemetery | | 24D. LOCATION (City, town, or county) (State) Great Mills, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 13 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7287 | |
|--|------------------|---|------------------------------|---|---|
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | 65 7287
Certificate of Death | | | |
| 2. DATE AND HOUR OF DEATH
7-10-65 6:01 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
Maryland 26-34 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
31 Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1214 Armistead Way | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
12-29-02 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 10B. KIND OF BUSINESS OR INDUSTRY
Mutual Chemical Co. | | 11. BIRTHPLACE (State or foreign country)
New York | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Anthony John Denny | | | |
| 14. MOTHER'S MAIDEN NAME
— | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
261-22-7085 | | 17. INFORMANT ADDRESS
RECORDS-BCH-4940 Eastern Avenue-21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)
581,04-163X | | CAUSE OF DEATH
(A) Gastrointestinal Hemorrhage
DUE TO
(B) Cirrhosis of the Liver
DUE TO
(C) — | | INTERVAL BETWEEN ONSET AND DEATH
1 day
6 mo to years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
Status eight years Post (R) Pneumonectomy for Carcinoma of Lung 8 years | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-23 19 65 to 7-10 19 65, that (I) (we) last saw the deceased alive on 7-10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H. Rathbun | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-10-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Howard Rathbun | | 23D. ADDRESS
M.D. BCH-4940 Eastern Avenue- #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-13-65 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore Cemetery | |
| 24D. LOCATION
Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
John C. Miller Inc. - 6415 Belair Road | | 25D. ADDRESS | |



BIRTH NO. 65

7288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7288

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD HAYWOOD

(MI L.)

2. DATE AND HOUR PRONOUNCED DEAD

9 July 1965

1:10 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore C ity Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE New York

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Bayshore L.I.

D. STREET ADDRESS (If rural, give location)

108 2nd. Ave.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11-4-1893

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CLERYMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OKLAHOMA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HENRY HAYWOOD

14. MOTHER'S MAIDEN NAME

LUCY PENONARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. EDWARD L. HAYWOOD (SAME)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVAL

23B. DATE

7-10-65

23C. NAME of CEMETERY or CREMATORY

PINE LAWN MEM. PARK

23D. LOCATION

(City, town, or county)

SUFFOLK CO

(State)

N.Y.

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SULLIVAN FUNERAL HOME
BAYSHORE L.I. NEW YORK

WALTER FORGE

HAS CONTENT

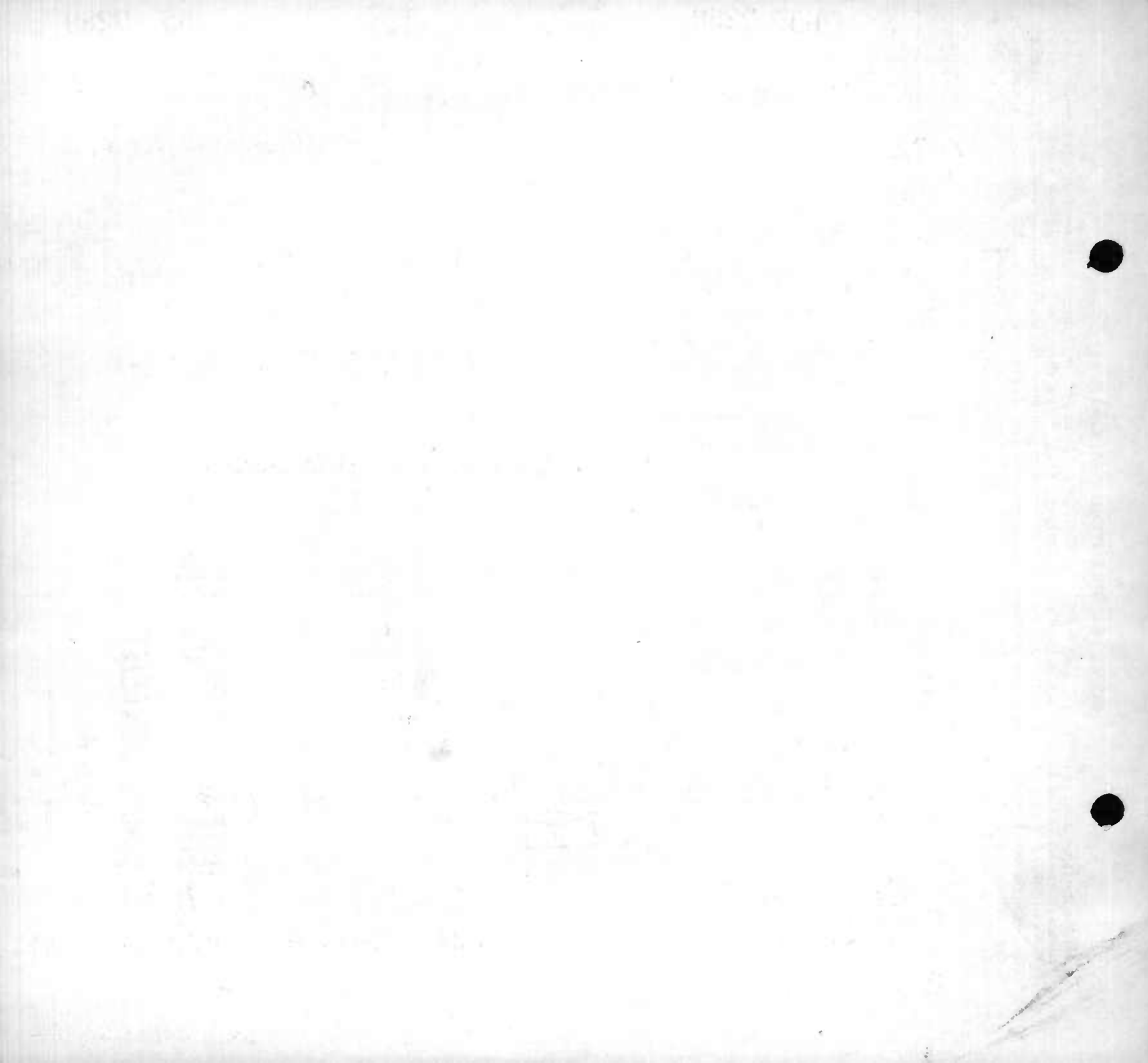
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7289 | |
|---|---|--|---|--|---|
| BIRTH NO. 65 7289 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Lillie Pettis | | | | 2. DATE AND HOUR OF DEATH
July 8, 1965 12:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bar-Wil-Bar Conv. Home | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location)
1 N-Kossuth St. | |
| 5. SEX
F | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
1890 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Accomac County, VA. | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
HANNAH Ayers | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
c ADDRESS | |
| 18. 450.01 CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Generalized arteriosclerosis | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
(B) DUE TO
(C) DUE TO | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-22-1963 to 7-8-1965 , that (I) (we) last saw the deceased alive on 7-7-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
C.R. Campbell | | | | 23B. DATE SIGNED
7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type)
C.R. Campbell | | 23D. ADDRESS
1618 W. North Ave., Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-13-65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | |
| 24D. LOCATION
Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
E. Lloyd Wilson | | | |
| 25D. ADDRESS
1000 Brantley Ave | | | | | |



| BIRTH NO. 65 7290 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 65 7290 | |
|---|---------|--|------------------|---|---|--|--|
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| IDA GAMBLE | | | | 7/13/65 2:40 a. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| 36 Franklin Square Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 713 Fairmount Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| female | colored | Widowed | JAN. 1, 1902 | 83 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | None | | Baltimore, Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Henry Carey | | | | Lottie | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | |
| 443X-260X | | | | | | | |
| Arteriosclerotic and hypertensive cardio-vascular disease | | | | | | | |
| 18B. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | | | |
| | | | | | | | |
| 18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| Diabetes Mellitus | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | no | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| | | | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | 7/13/65 | | | |
| warner U. Spitz, M.D. | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 7-15-65 | | BALTO. NAT. Cem. | | Baltimore Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 13 1965 | | Robert E. Fairley, M.D. | | C. O. Wilson | | 1000 Broadview Ave | |

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BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES CARTER SNIPES

2. DATE AND HOUR PRONOUNCED DEAD

7/12/65 5:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3001 Southland Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

May 4 - 1933

9. AGE (In years
last birthday)

32

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George W. Snipes

14. MOTHER'S MAIDEN NAME

Lillie Preston

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL
SECURITY NO.

17. INFORMANT

Sylvia Snipes

ADDRESS

Same

18.

581.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-16-1965

23C. NAME OF CEMETERY or CREMATORY

Baltimore

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUL 13 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Choyce Wilson Mrs. Beauty

ADDRESS

ISSN 0013-788X

ISSN 0013-788X

WALFLEX MONITOR

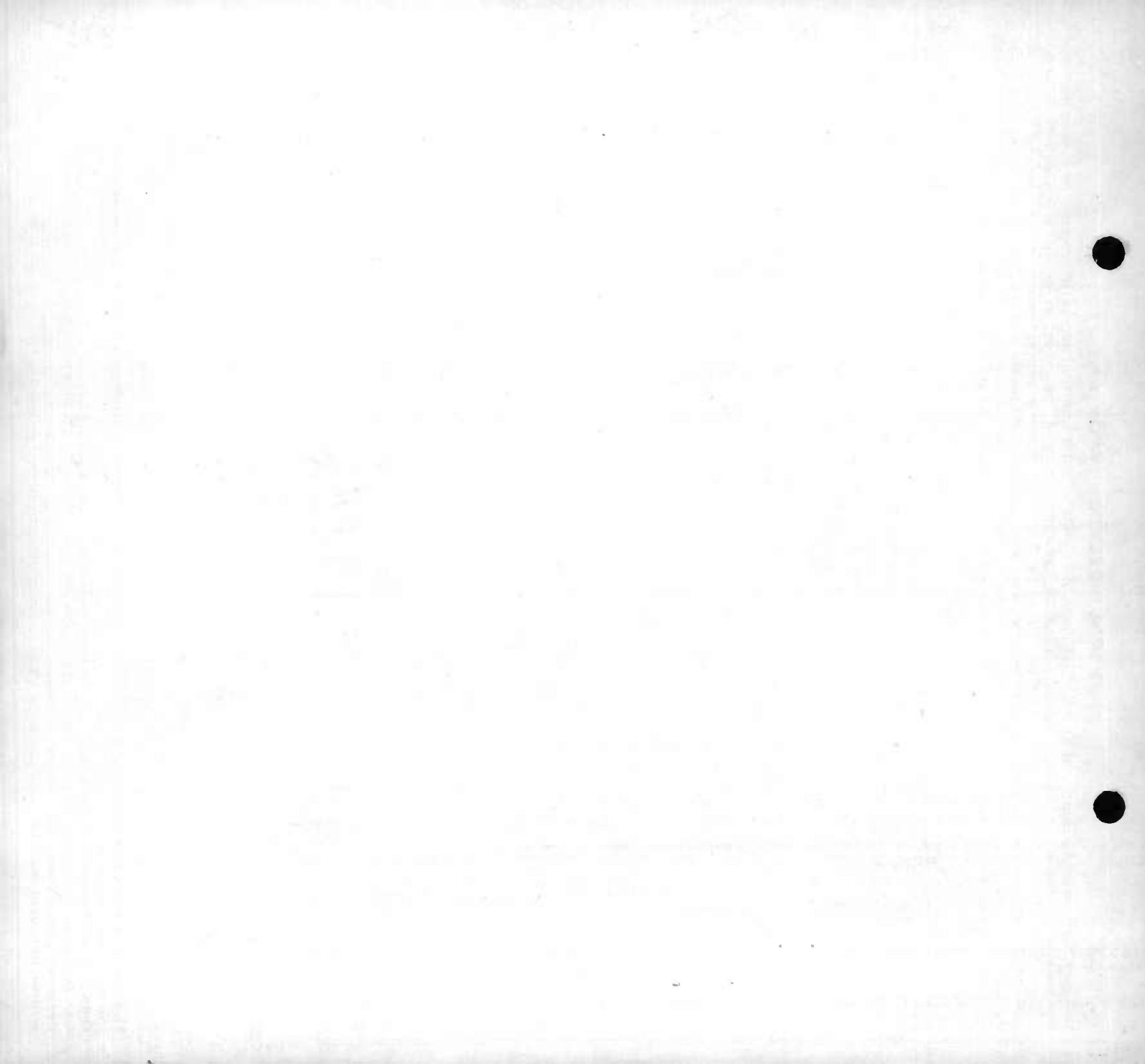
NOT CONTENT

1-1-1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7292 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7292 | |
|---|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Thomas Hipple</i> | | | | 2. DATE AND HOUR OF DEATH
<i>7-3-65 3:35 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>43 South Baltimore Gen. Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE
<i>MD</i> | | B. COUNTY
<i>Harmon St.</i> | |
| 5. SEX
<i>m</i> | | 6. RACE
<i>w</i> | | C. CITY OR TOWN
<i>Baltimore Maryland</i> | | D. STREET ADDRESS
<i>22-01</i> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Never married</i> | | 8. DATE OF BIRTH
<i>1-15-1904</i> | | 9. AGE (In years last birthday)
<i>61</i> | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>163x I SQUAMOUS CARCINOMA OF THE LUNG</i> | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1+ month</i> | | | |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO
(C) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <i>Dr.</i> (this hospital) attended the deceased from <i>5-30-1965</i> to <i>7-3-1965</i> , that (I) <i>Dr.</i> last saw the deceased alive on <i>7-3-1965</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>Dr.</i> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Dr. M. Kaufman</i> | | | | 23B. DATE SIGNED
<i>7-3-65</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>Dr. M. Kaufman</i> | |
| 23D. ADDRESS
<i>South Baltimore General Hospital</i> | | | | 23E. FUNERAL DIRECTOR ADDRESS | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | 24B. DATE
<i>JUL 9 1965</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>ANATOMY BOARD OF MARYLAND</i> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 13 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR
<i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i> | | 25D. ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or indirect cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Unusual medical case; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

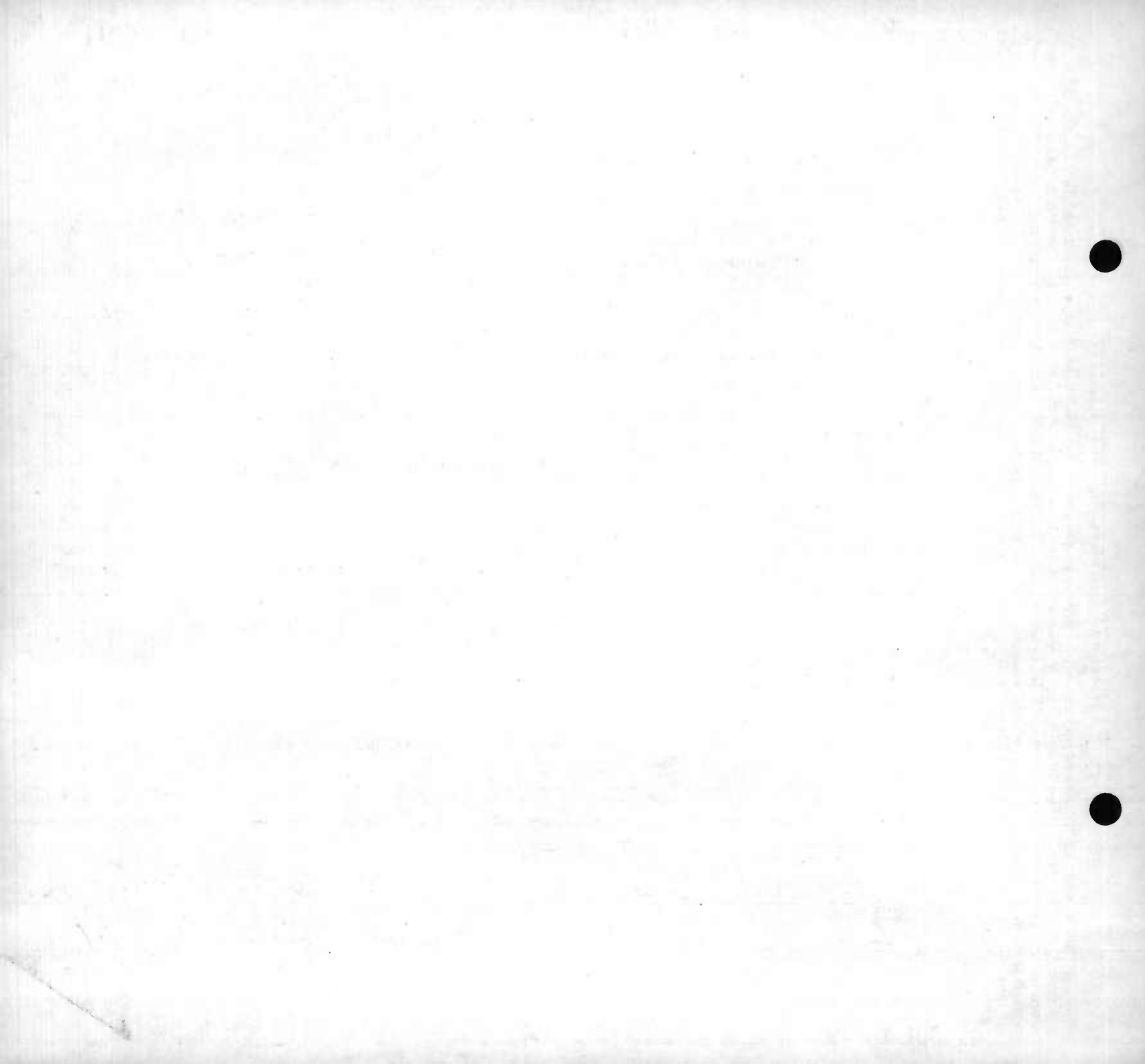
| | | | | | |
|--|---|--|--|---|--|
| BIRTH NO.
65 7293 | | BALTIMORE CITY HEALTH DEPARTMENT
Certificate of Death | | Registered No. 65 7293 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) LEO NOVAK | | 2. DATE AND HOUR OF DEATH
JUNE 30 '65 11:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 17.
D. STREET ADDRESS (If rural, give location) 1803 Cutaw Place | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) 86 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
420.1 + F904.7
Myocardial Infarction
femoral neck | | 19. CAUSE OF DEATH
fx (R) femoral neck,
Old myocardial infarction + emphysema | | INTERVAL BETWEEN ONSET AND DEATH
not known correctly | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing city | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | 1803 Cutaw Place, Baltimore | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) not correctly known | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? Fall | | | |
| 22. I certify that (we) (this hospital) attended the deceased from June 29 19 65 to June 30 19 65, that (we) last saw the deceased alive on June 30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John Derek Hsu | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
June 30/65 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN DEREK HSU | | 23D. ADDRESS
JOHNS HOPKINS HOSP. BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
JUL 8 1965 | 24C. NAME OF CEMETERY OR CREMATION
ANATOMY BOARD OF MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | 25B. NAME OF REGISTRAR
Robert E. Fairley | 25C. FUNERAL DIRECTOR
MORTUARY SERVICE - BCHD | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|--|---|---|
| BIRTH NO. 65-05154 65 7294 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7294 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) STEM, SARAH | | | 2. DATE AND HOUR OF DEATH
JULY 5, 1965 5:05 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

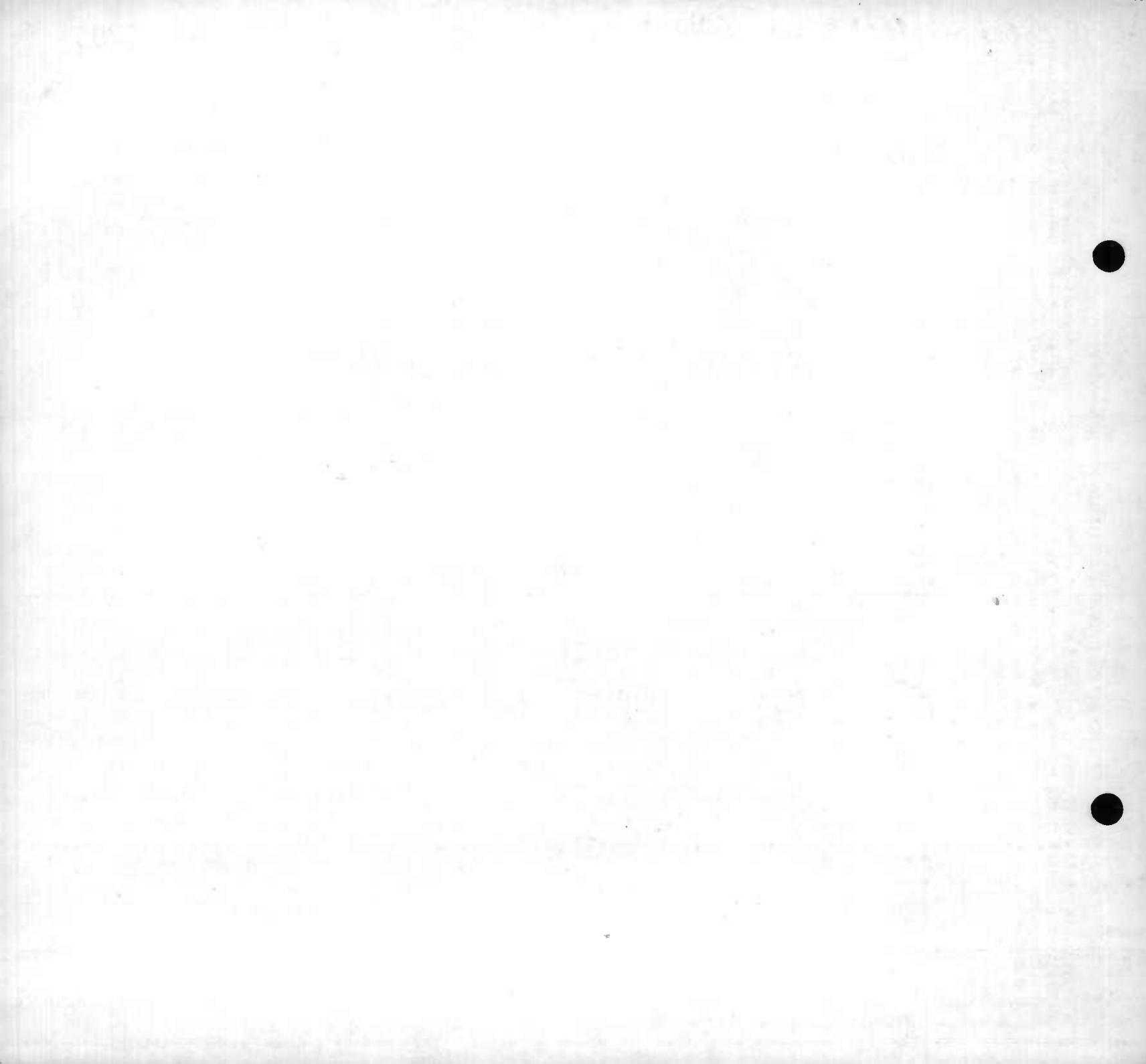
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MARYLAND GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
GLYNDON 53-00
D. STREET ADDRESS (If rural, give location)
Box 99, RAILROAD AVE. | | |
| 5. SEX
F | 6. RACE
CAUCASIAN | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
3/3/65 | 9. AGE (In years lost birthday)
42 | 10. Under 1 Yr. Months: Days: Hours: Min.
4 2 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
RICHARD WILLIAM STEM, SR | | | 14. MOTHER'S MAIDEN NAME
ROSEMARY BETTY CARPER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. 784.1.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CONGENITAL HEART DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH
4 mos 2 days | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
6/20/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
① type of infection ② duodenotomy | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 6-11-1965 to 7-5-1965 , that (2) (we) lost saw the deceased alive on July 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death. | | | | | |
| 23A. SIGNATURE
Louis O. Olsen | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 5, 1965 |
| 23C. PHYSICIAN'S NAME (Type)
LOUIS O. OLSEN | | | 23D. ADDRESS
Maryland General Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
JUL 8 1965 | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town or County) (State) |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

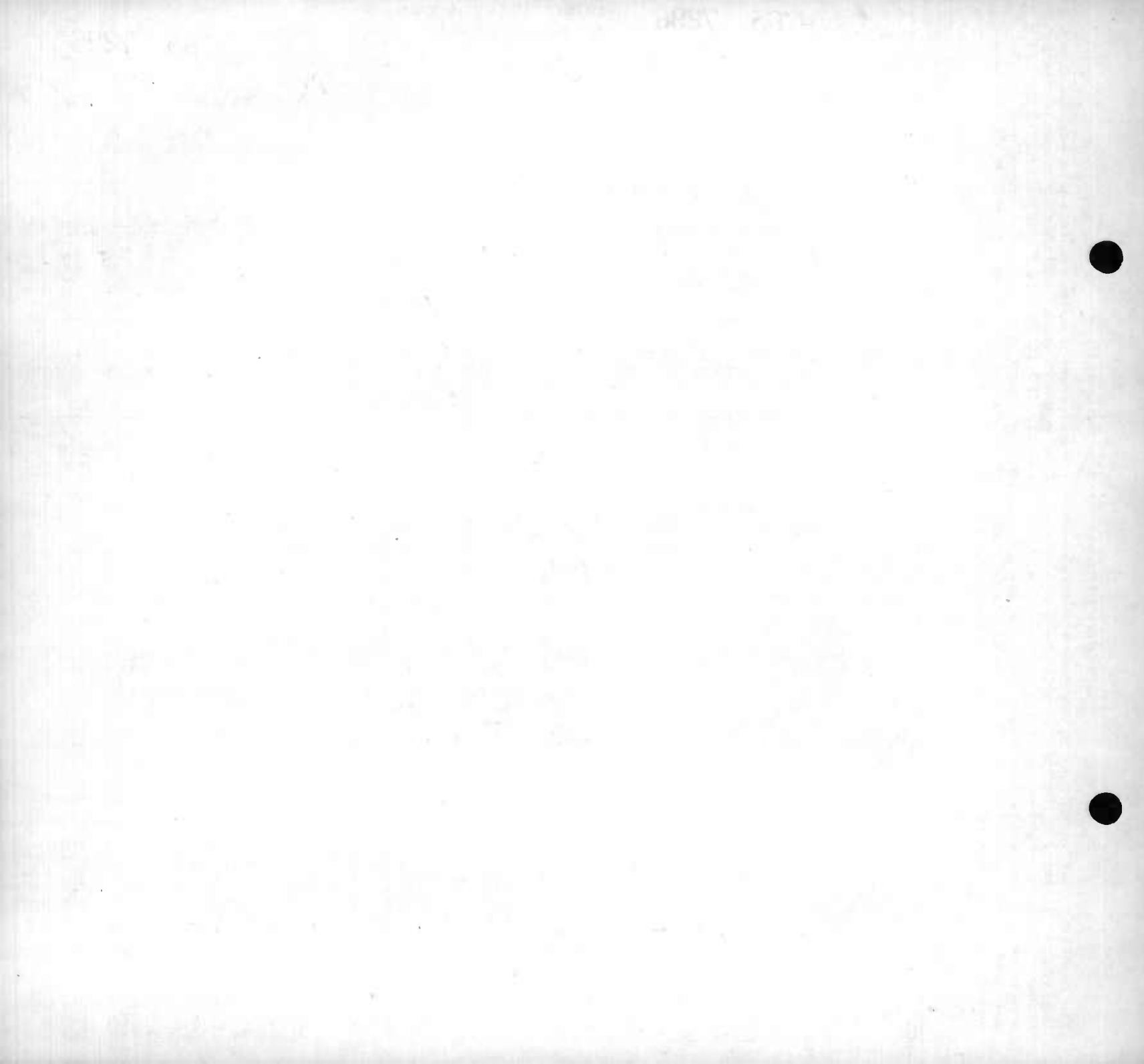
| BIRTH NO. <u>65-1580965</u> <u>7295</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65</u> <u>7295</u> | |
|---|-------------------------|--|--|--|---------------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Baby Girl DELANO</u> | | | | 2. DATE AND HOUR OF DEATH
<u>July 1, 1965</u> <u>8:53</u> A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>md. GEN. Hosp.</u> | | (If not in hospital or institution, give street address or location) | | A. STATE
<u>md.</u> | | B. COUNTY
<u>BALTO.</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTO. #36</u> <u>53-00</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<u>110 LESLIE AVE</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. RACE
<u>white</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>N.B.</u> | 8. DATE OF BIRTH
<u>JUNE 30, 1965</u> | | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>GEORGE HENRY DELANO</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>HELEN FRANCES WHITE</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>mother</u> | | ADDRESS
<u>SAME</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>776X I</u> | | | | CAUSE OF DEATH
(A) DUE TO <u>Immaturity</u>
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>✓</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6-30</u> 19 <u>65</u> to <u>7-1</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>7-1</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<u>Tamara La</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>7-1-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
<u>JUL 8 1965</u> | | 24C. NAME OF CEMETERY OR CREMATORY
<u>ANATOMY BOARD OF MARYLAND</u> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 13 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. F...</u> | | 25C. FUNERAL DIRECTOR
<u>MORTUARY SERVICE - BCHD</u> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician, who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

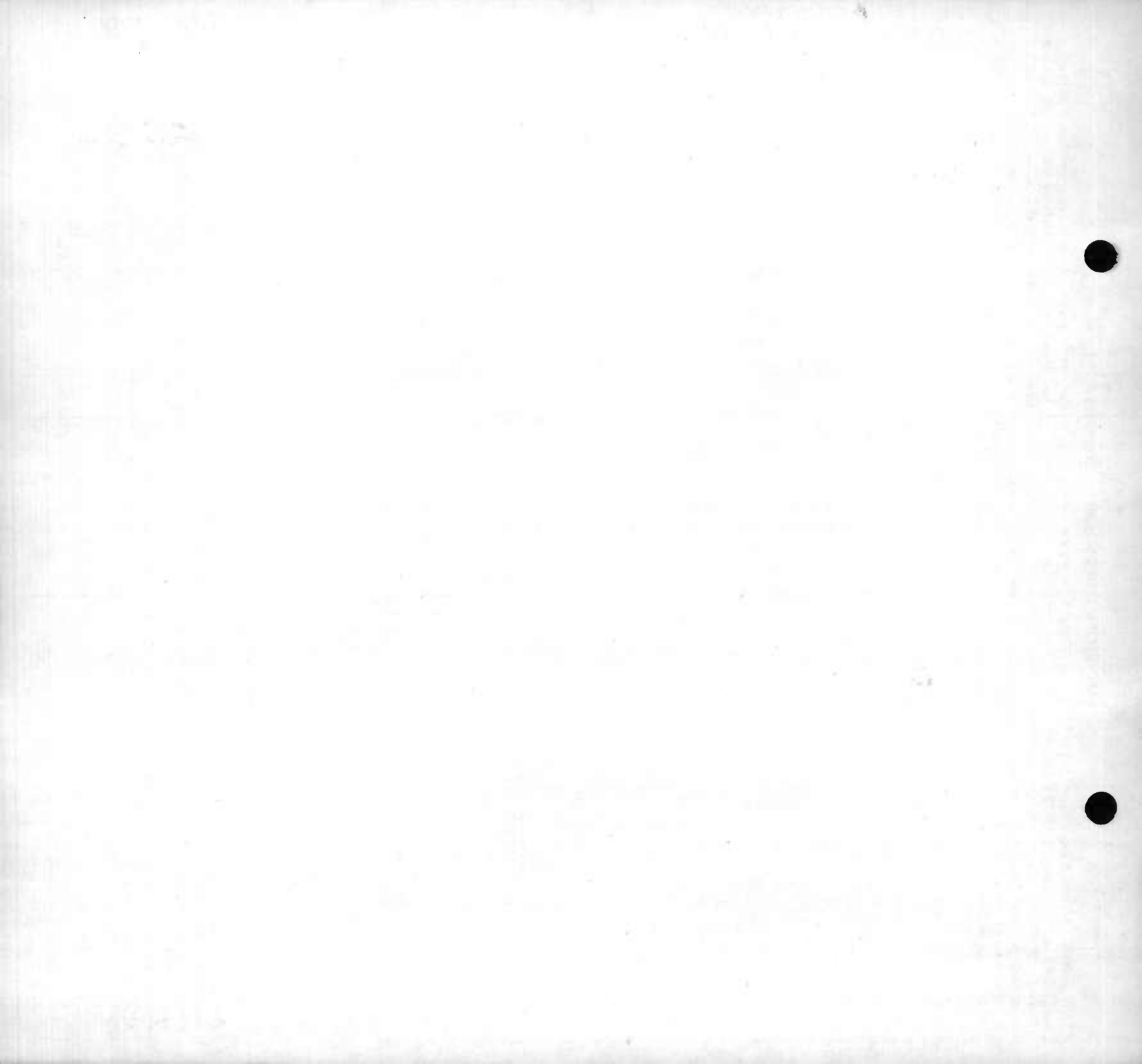
| BIRTH NO. 65-1624555 7296 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7296 | |
|---|---------------------|---|---|--|---|--|--|
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) BABY BOY ATTERS | | | | 2. DATE AND HOUR OF DEATH
6-28-65 10⁰⁹ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
38 UNIVERSITY HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE
MD. | | B. COUNTY
4-02 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
724 W. SARATOGA | | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
newborn | 8. DATE OF BIRTH
6-28-65 | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEWBORN | | 10B. KIND OF BUSINESS OR INDUSTRY
— | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
WILLIAM GRAYSON CROCKETT | | | | 14. MOTHER'S MAIDEN NAME
ETHEL TOWE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
(HOSPITAL CHART) | | ADDRESS | | |
| 18. 759.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
MASSIVE ASPIRATION SYNDROME | | | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
5^{HR}-42' | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO
MULTIPLE CONGEN. ANOM. | | 5^{HR}-42' | |
| | | | | (C) | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
0 | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (A) (this hospital) attended the deceased from 6-28-65 to 6-28-65 , that (B) (we) last saw the deceased alive on 6-28-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Albert M. Gordon | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
6-28-65 | |
| 23C. PHYSICIAN'S NAME (Type)
ALBERT M. GORDON | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
JUL 8 1965 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY
ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (City, town, county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
UNIVERSITY MEDICAL SCHOOL | | ADDRESS
MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7297 | |
|---|--|--|--|---|--|
| BIRTH NO. 65-14994 7297 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Baby Boy JEFFERSON | | 2. DATE AND HOUR OF DEATH
6-20-65 12.45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIVERSITY HOSPITAL | | A. STATE MD. B. COUNTY 25.32 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| 5. SEX M 6. RACE C | | D. STREET ADDRESS (If rural, give location)
1204 Cherry Hill Rd | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) - | | 8. DATE OF BIRTH
6-20-65 | | 9. AGE (In years last birthday) 6 10. Under 1 Yr. Months 6 11. Under 24 Hrs. Min. 15 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Jerome Jefferson | | 14. MOTHER'S MAIDEN NAME
Marsha - | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT
CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
773.0 I | | CAUSE OF DEATH
(A) HYALINE MEMBRANE DIS.
DUE TO
(B) -
DUE TO
(C) - | | INTERVAL BETWEEN ONSET AND DEATH
6 hrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) - | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-20-65 (8:30 AM) to 6-20-65 (2:45 PM) that (I) (we) last saw the deceased alive on 6-20-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Carlos Abel | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
6-20-65 | |
| 23C. PHYSICIAN'S NAME (Type)
CARLOS ABEL | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
JUL 8 1965 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY
ANATOMY BOARD OF MARYLAND | |
| 24D. LOCATION
UNIVERSITY MEDICAL SCHOOL | | 24E. ADDRESS
MORTUARY SERVICE - BCHD | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

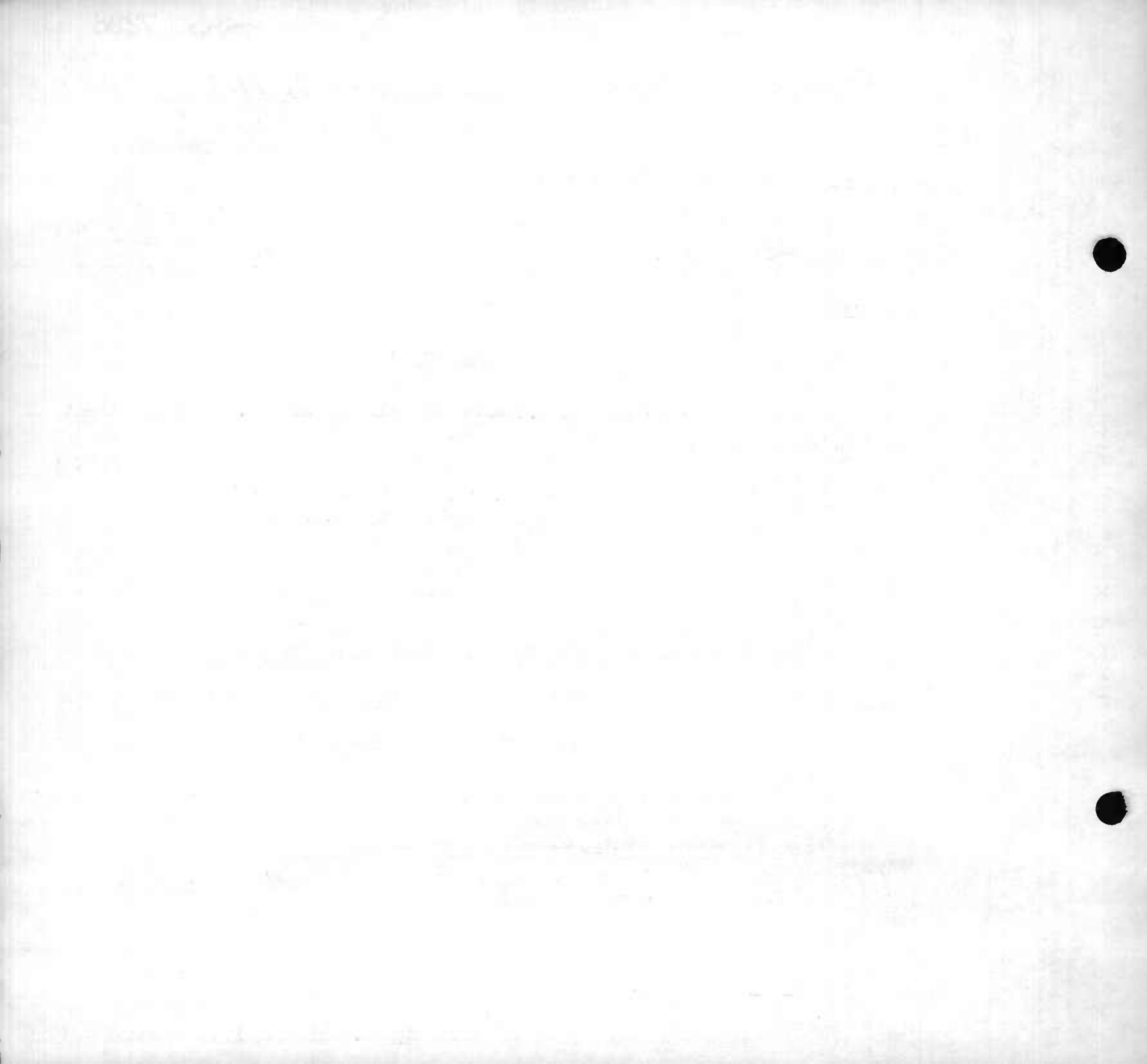
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7298 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7298 | |
|--|-------------------------|---|--|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) FULLER, HANNAH | | | | 2. DATE AND HOUR OF DEATH
JULY 7, 1965 8:05 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF BALTIMORE
42 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 70-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2009 W. MULBERRY ST. | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
NOV. 11, 1895 | 9. AGE (In years last birthday)
79 | If Under 1 Yr.
Months: Days: Hours: Min. | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Smith | | | 14. MOTHER'S MAIDEN NAME
Emma Hillin | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-20-5244 | | 17. INFORMANT
Ella Mae Hall | | ADDRESS
2009 W. Mulberry Street | |
| 18. 332X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) CEREBRAL THROMBOSIS
DUE TO
HYPERTENSIVE ARTERIO-
SCLEROTIC VASCULAR DISEASE
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
5 DAYS | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 2 1965 to JULY 7 1965 , that (I) (we) lost saw the deceased olive on JULY 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Herbert Fellerman | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 7, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Herbert Fellerman | | | | 23D. ADDRESS
M.D. Arlington S. Phillips 1727 Monroe Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-11-65 | | 24C. NAME of CEMETERY or CREMATORY
Western Star | | 24D. LOCATION (City, town, or county) (State)
Catonsville Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
Arlington S. Phillips 1727 Monroe Street | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7299 | |
|--|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. 65 7299 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Howard Ruffin (Howard)</i> | | 2. DATE AND HOUR OF DEATH
<i>7/8/65 - 8:45 AM.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>46 Lutheran Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>MD.</i> B. COUNTY <i>16-CLY</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>606 - N. Rayson St.</i> | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>12/2/21</i> | 9. AGE (In years lost birthday)
<i>43</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Longshoreman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Shipping</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore, Md.</i> | |
| 13. FATHER'S NAME
<i>William Ruffin</i> | | 14. MOTHER'S MAIDEN NAME
<i>Evelyn Robinson</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>219-018782</i> | | 17. INFORMANT ADDRESS
<i>Margaret Ruffin 1603 Balmar St.</i> | |
| 18. <i>331X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH
(A) <i>C.I.A.</i>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Introcerebral Hemorrhage</i>
DUE TO | | | |
| | | (C) <i>Hypertension</i> | | <i>9 yrs</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 8, 1965</i> to <i>July 8, 1965</i> , that (I) (we) last saw the deceased alive on <i>July 8, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Robert E. Blackman</i> M.D. | | | | 23B. DATE SIGNED
<i>7/8/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Dr. Robert Blackman</i> M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7/13/65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Baltimore National</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 13 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher</i> | |
| 25C. FUNERAL DIRECTOR
<i>Wilmington S. Phillips</i> | | 25D. ADDRESS
<i>1727 N. Moore</i> | | | |

William Jackson
George Jackson
Margaret Jackson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

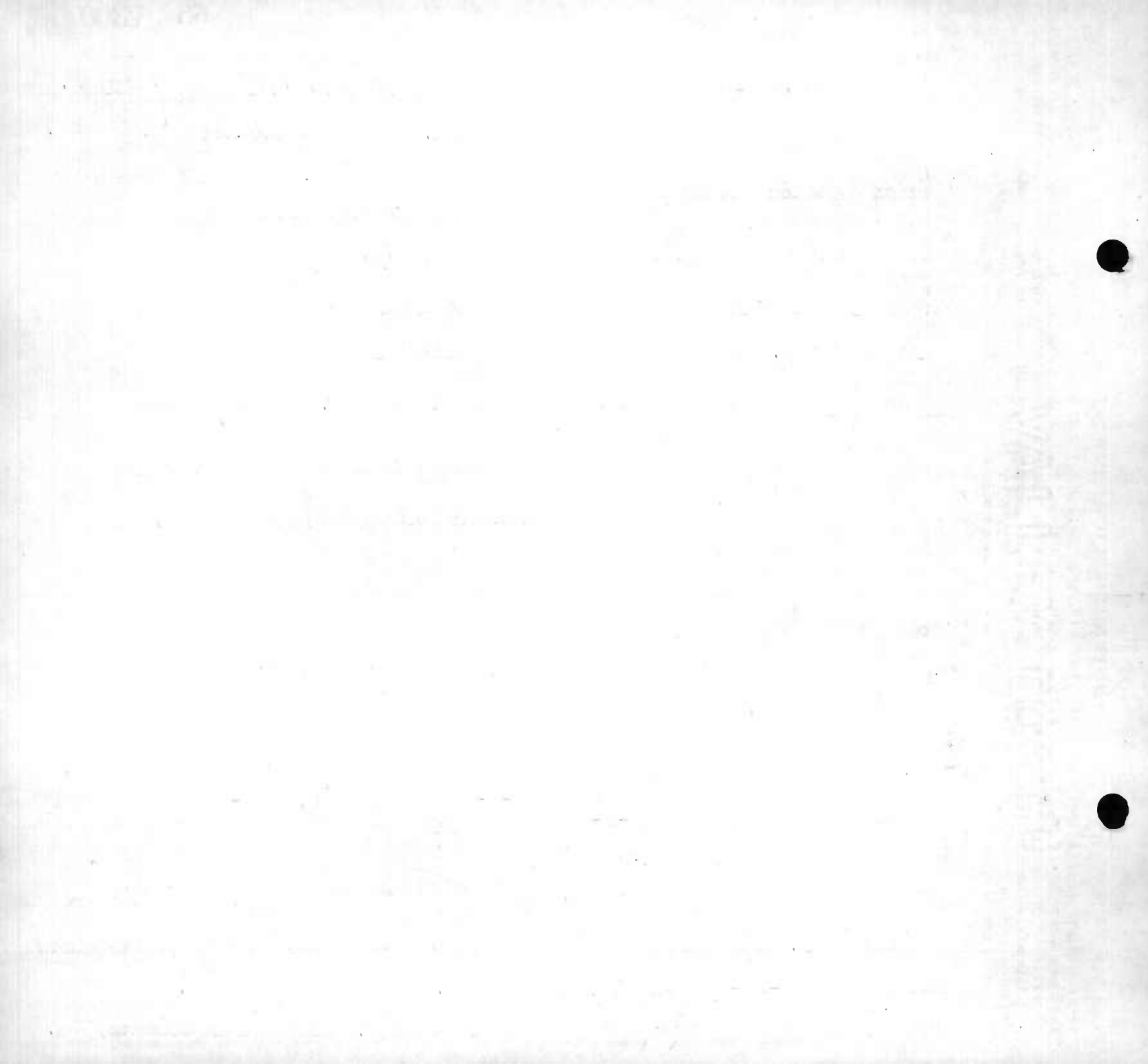
| BIRTH NO. 65 7300 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7300 | |
|--|-------------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Charles Frederick Vogel</i> | | | | 2. DATE AND HOUR OF DEATH
<i>July 7, 1965</i> <i>12:35 P.</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>44 Union Memorial Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Cockeysville</i> <i>53-00</i>
D. STREET ADDRESS (If rural, give location)
<i>302 A Boxerhill Road</i> | | | |
| 5. SEX
<i>male</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>married</i> | 8. DATE OF BIRTH
<i>July 4, 1913</i> | 9. AGE (In years last birthday)
<i>52</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Arcade Floors Inc</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Frederick G. Vogel</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Nettie Fetch</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>218280965</i> | | 17. INFORMANT
<i>Mrs Mildred V. Vogel</i> | | ADDRESS
<i>same</i> | |
| 18. <i>420.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

<i>II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <i>Coronary Occlusion</i>
DUE TO
(B) <i>Coronary Artery Disease</i>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>sudden</i>

<i>1 year</i> | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>no</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7-2-</i> <i>19 65</i> to <i>7-7</i> <i>19 65</i> , that (I) we lost saw the deceased alive on <i>7-2-</i> <i>19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Charles F. O'Donnell</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>7/8/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Charles F. O'Donnell</i> | | | | 23D. ADDRESS
<i>7501 York Road, Towson 4, Maryland</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | 24B. DATE
<i>7-10-65</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Dulaney Valley Mem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 13 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fairley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | |
|---|---------|--|---|--|----------------------------------|
| 65 7301 | | | | 65 7301 | |
| M-620 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| EDGAR C. MYERS | | | 7-12-65 5:40 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE
B. COUNTY | | |
| 44 UNION MEMORIAL HOSPITAL | | | Maryland | | |
| | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 3610 Greenmount Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months, Days |
| Male | White | Married | April 16, 1902 | 62 63 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | |
| Garage Owner | | | Maryland | | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Herbert J. Myers | | | U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | | 14. MOTHER'S MAIDEN NAME | | |
| | | | Sarah E. Farver | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| 212221869 | | | Mrs. Marjorie F. Myers Same | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| (A) Ruptured Berry aneurysm of left anterior cerebral artery of brain | | | | | |
| (B) DUE TO | | | | | |
| (C) | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | PETER W. RIECKERT, MD | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 7/15/65 | | Loudon Park Cemetery | |
| | | | | 23D. LOCATION (City, town, or county) (State) | |
| | | | | Balto., Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| JUL 13 1965 | | Robert E. Farber, MD | | Leonard J. Ruck, Inc., Balto., Md. | |

1021

WALLER & CO. INC.

NEW YORK

NOV 10 1901

FUNERAL DIRECTOR: IMPORTANT

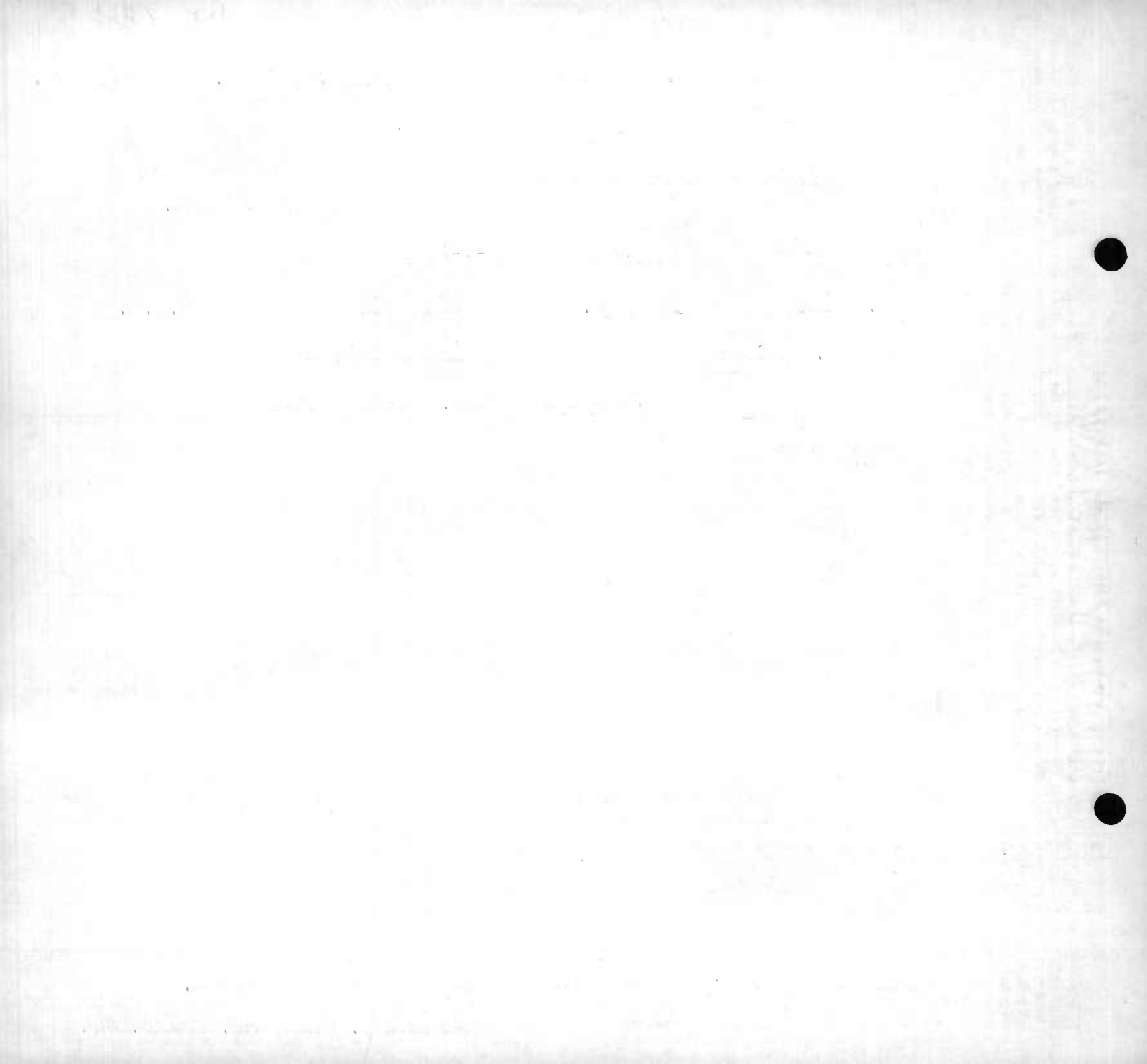
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7302 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7302 | | |
|---|-------------------------|--|-------------------------------------|---|--|--|-----------------------|----------------------------------|
| 1. NAME OF DECEASED
(Type or Print) <i>Ernest C. Calhoun</i> | | | | 2. DATE AND HOUR OF DEATH
<i>July 10, 1965. 11:52 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>44 Union Memorial Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE <i>Md.</i> B. COUNTY <i>21-06</i> | | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore #14</i> | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>5513 Pilgrim Rd.</i> | | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Married</i> | 8. DATE OF BIRTH
<i>3-4-1905</i> | 9. AGE (In years last birthday)
<i>60</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Mgr. Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Food Co.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | |
| 13. FATHER'S NAME
<i>Calvin C. Calhoun</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Lelia Drinkard</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>182078382</i> | | 17. INFORMANT
<i>Mrs. Susie Calhoun</i> | | ADDRESS
<i>Same</i> | | |
| 18. <i>420.1 9-180X</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

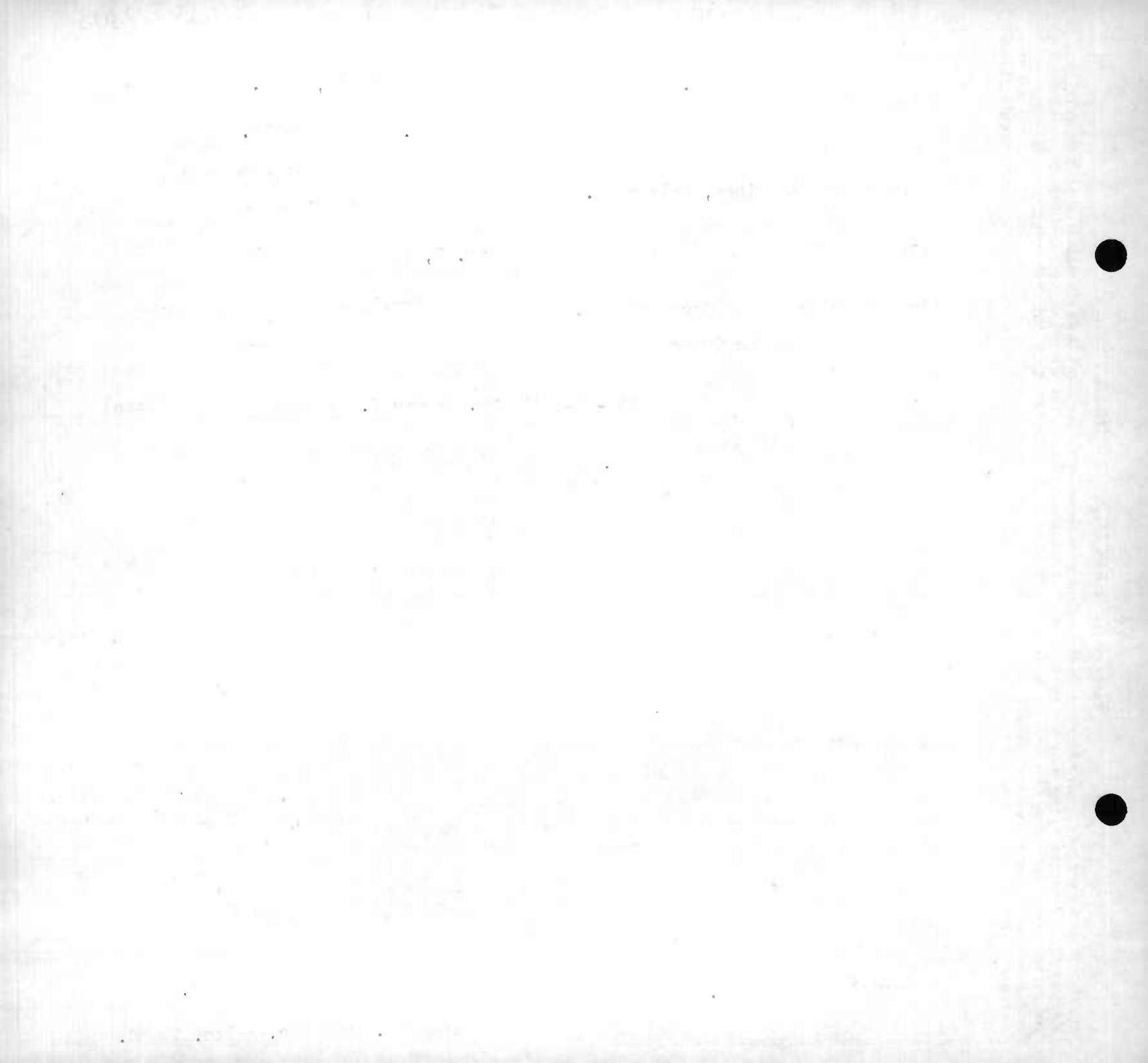
<i>II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) <i>stroke Cerebral accident</i>
DUE TO
(B) <i>High Blood Pressure, Coronary Arteriosclerosis</i>
DUE TO
<i>Wining Bladder Tumor Malignant</i> | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
<i>6/19/64</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Recurrent bladder tumor</i> | | 20A. AUTOPSY? (Yes or No) | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/13</i> 19 <i>59</i> to <i>Aug</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5/6/65</i> 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | |
| 23A. SIGNATURE
<i>John S. Haines M.D.</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>7/12/68</i> | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>John S. Haines</i> | | | | 23D. ADDRESS
<i>11 E Chase St. Balto 2nd</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7/14/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Woodlawn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 13 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck, Inc., Balto., Md.</i> | | ADDRESS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7303 | |
|--|---------|--|--------------------------|--|----------------------------------|
| BIRTH NO. | | 65 7303 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Edward J. Mc Creer | | July 10, 1965. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 90 House in the Pines, Belair Rd. | | Md. Balto. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore # 34 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 9114 Hines Road 53.00 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr. Months Days |
| Male | White | Widowed | Jan. 9, 1882 | 83 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Retired Chauffeur | | Coco Cola Co. | | Maryland | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Thomas Mc Creer | | | Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or doles of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 216-03-1010 | | Mr. Norman T. Mc Creer (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES | | (A) DUE TO | | | 3 yrs |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 1966 to July 10 1965, that (I) (we) last saw the deceased alive on July 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Conrad L. Richter M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Conrad L. Richter M.D. | | | | 3128 Harford Rd. Baltimore Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7/14/65 | | Holy Redeemer Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 13 1965 | | Robert E. Feltner M.D. | | Leonard J. Ruck Inc. Balto. 14 Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65-7304 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65-7304 | |
|--|---------------------|--|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Catherine A. Hobbs</i> | | | | 2. DATE AND HOUR OF DEATH
<i>July 11, 1965 8:20 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Maryland Gen. Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE
<i>Maryland</i> | | B. COUNTY
<i>27-07</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>2515 Moore Av. AVE</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>W</i> | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED
<input type="checkbox"/> WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
<i>10-30-96</i> | 9. AGE (In years last birthday)
<i>68</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA.</i> | |
| 13. FATHER'S NAME
<i>John T. - (Dever)</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Augusta C. Keller</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<i>213105448B</i> | | 17. INFORMANT
<i>Oliver Hobbs - same</i> | | ADDRESS | |
| 18. <i>570.1 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
<i>Paralytic ileus</i>
(A) DUE TO <i>Aspiration Pneumonia</i>
(B) DUE TO <i>Paralytic ileus</i>
(C) <i>Megacolon (Idiopathic)</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>10-12-64</i> | | | |
| 19A. DATE OF OPERATION
<i>July 10, 1965</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Intestinal Obstruction</i> | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-14-65</i> 19 to <i>July 11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 11</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Leonard J. Ruck, Inc.</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>July 11, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
<i>Maryland Gen. Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Entombment</i> | | 24B. DATE
<i>7/14/65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Lorraine Mausoleum</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 13 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Leonard J. Ruck, Inc., Balto., Md.</i> | | ADDRESS | |

Refugees (Aboriginal)
Refugees (Aboriginal)

July 10, 1962 International Commission
Yes Yes

FUNERAL DIRECTOR: IMPORTANT

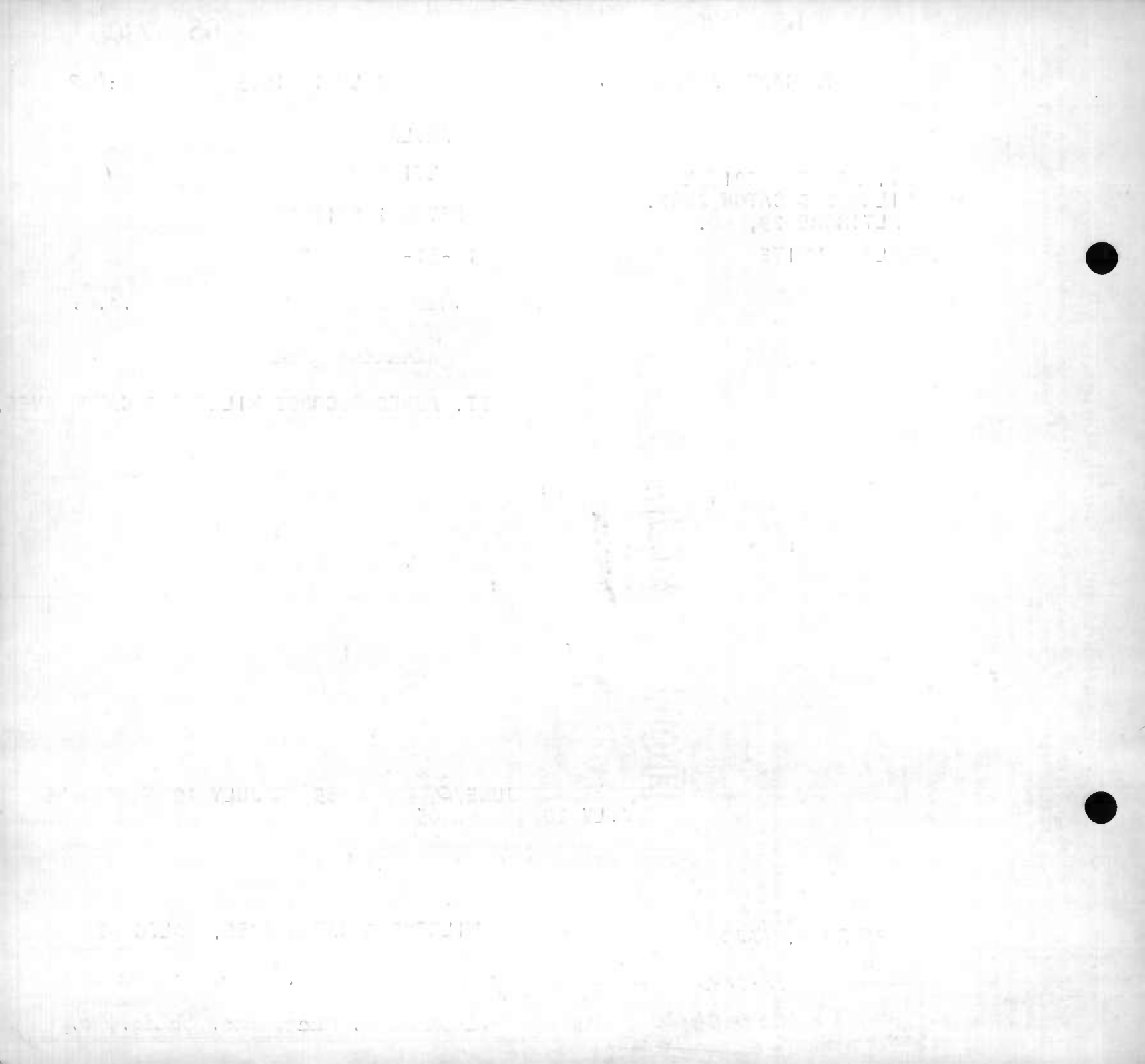
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|--|------------------------------|--|----------------------------|--|--|
| BIRTH NO. 65 7305 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 7305 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) TAGGART, BARBARA J. | | 2. DATE AND HOUR OF DEATH
JULY 10 1965 1:40P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
WILKENS & CATON AVES.
BALTIMORE 29, MD. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
SETON INSTITUTE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
10-31-82 | 9. AGE (In years lost birthday)
82 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
New York | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Eppig | | | | 14. MOTHER'S MAIDEN NAME
Catharine Eich | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
ST. AGNES RECORDS WILKENS & CATON AVES | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, which arose in the above cause (A) slowing or hastening the UNDERLYING CONDITION lost.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO General arteriosclerosis with coronary thrombosis
(B) DUE TO Post. hip fracture (Hip Surgery) 6/14/65
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
6-14-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Hip Fracture | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
Seton Institute | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Bedroom - Seton Institute | | 21D. TIME OF INJURY (APPROX.)
11:50 P.M. - 6-9-65 | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Slipped from bed to floor | | 22. I certify that (I) (this hospital) attended the deceased from JUNE 10 1965 to JULY 10 1965, that (I) (we) last saw the deceased alive on JULY 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
Pedro F. Bajo | |
| 23C. PHYSICIAN'S NAME (Type)
PEDRO F. BAJO | | 23D. ADDRESS
WILKENS & CATON AVES. BALTO #29 | | 23B. DATE SIGNED | | 23E. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/13/65 | | 24C. NAME of CEMETERY or CREMATORY
Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State)
Wilmington, Delaware | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 13 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fadden | | 25C. FUNERAL DIRECTOR
Leonard J. Rubk, Inc., Balto., Md. | | 25D. ADDRESS | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH CARROLL

2. DATE AND HOUR PRONOUNCED DEAD

9 July 1965

11:45 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 29

D. STREET ADDRESS (If rural, give location)

305 Mt. Holly St.

5. SEX

male

6. RACE

White
caucasian7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 24, 1906

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

W.M.R.R.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Carroll

14. MOTHER'S MAIDEN NAME

Mary Yeager

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

705 10 5033

17. INFORMANT

ADDRESS

Mrs. Lillian E. Carroll, 305 Mt. Holly St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerptic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

7/13/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

Balto. 29, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 14 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

ADDRESS

300

WATER

Cherry

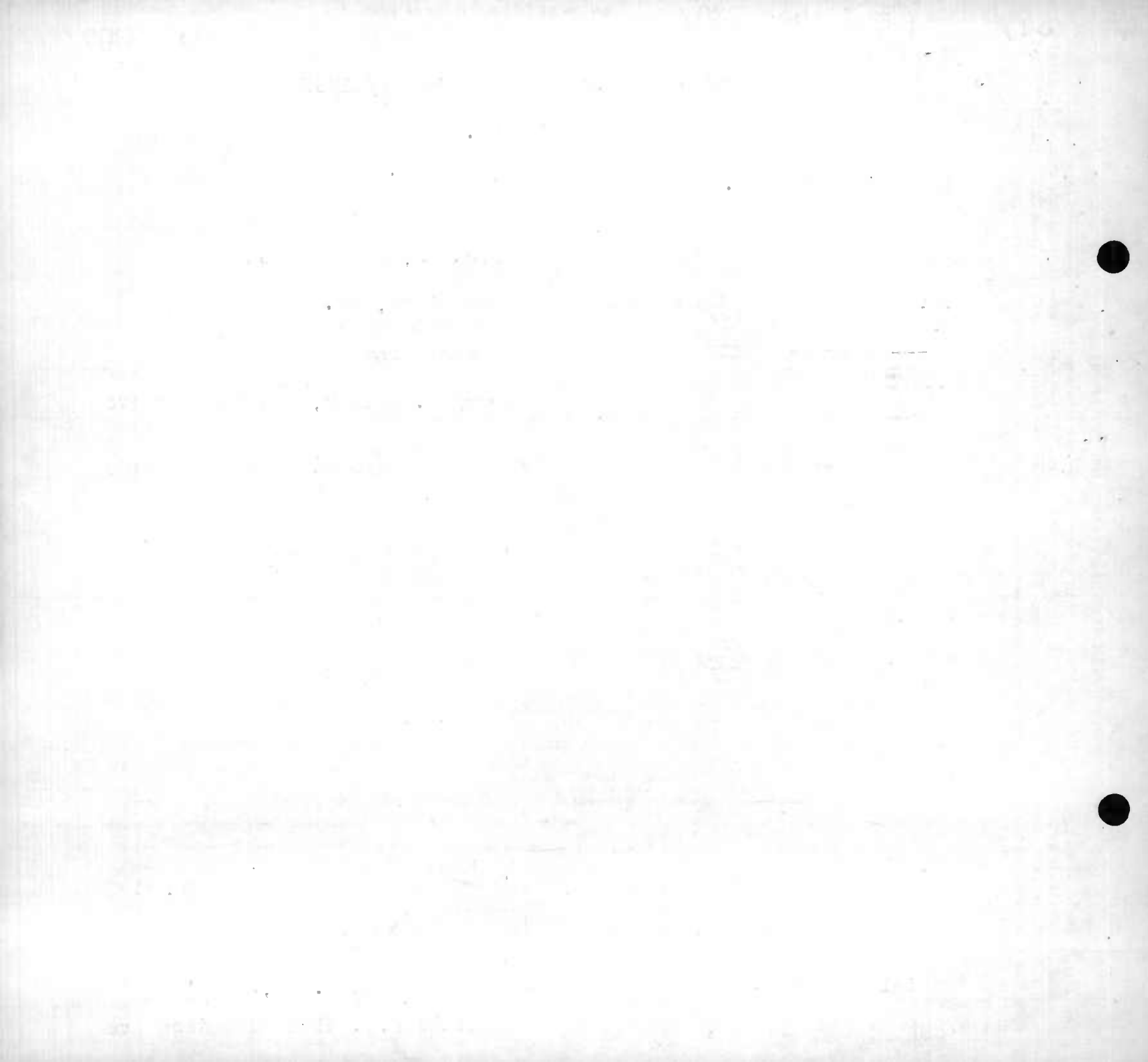
100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

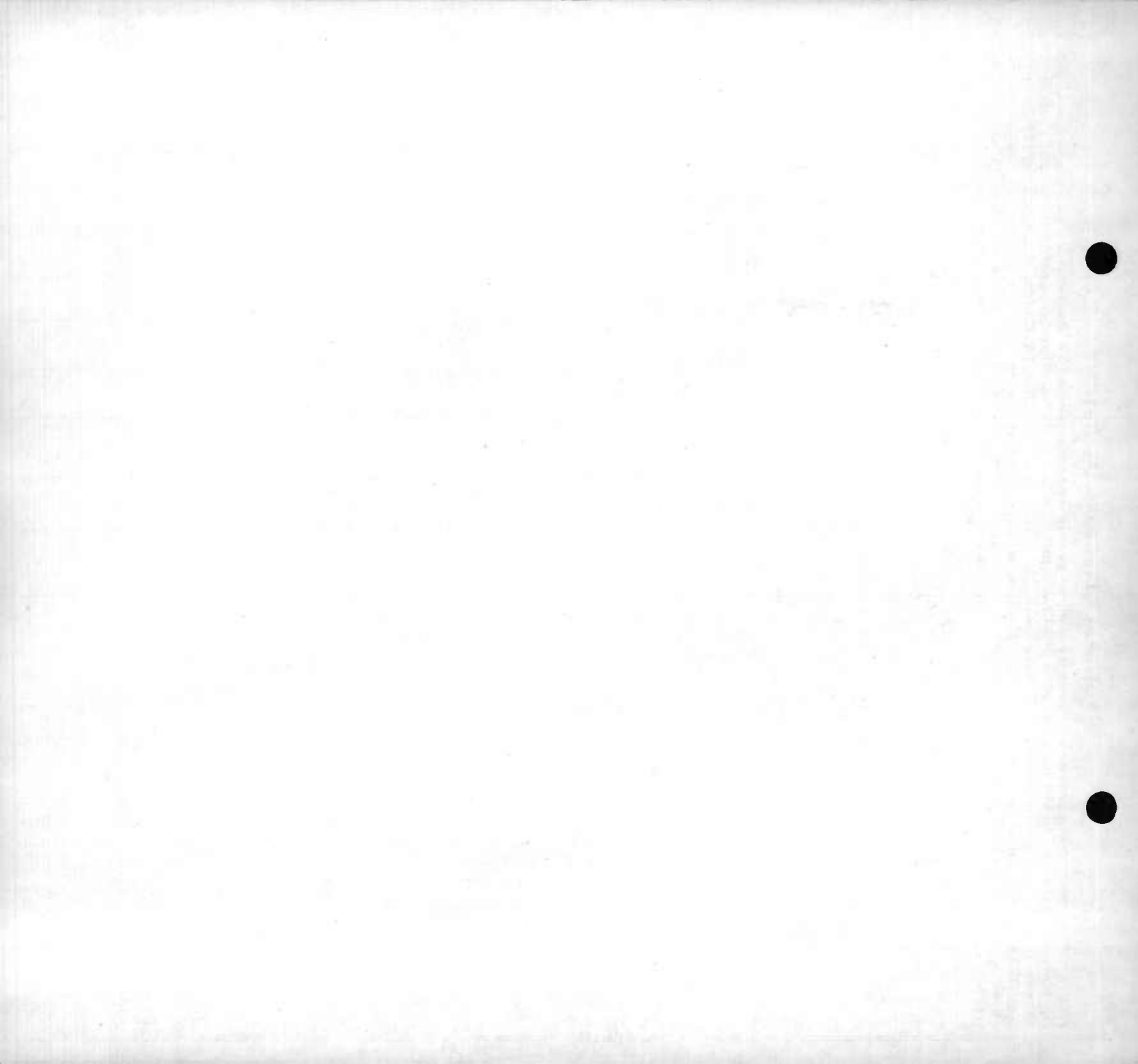
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7307 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 65 7307 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Mary Louise Keller | | 2. DATE AND HOUR OF DEATH
7/11/65 about 1 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
1338 Glyndon Ave. | | A. STATE Ma.
B. COUNTY 21-02 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto. | | | |
| | | D. STREET ADDRESS (If rural, give location)
1338 Glyndon Ave | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
Married | 8. DATE OF BIRTH
Jan. 23, 1903 | 9. AGE (In years last birthday)
62 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
D.W. | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Cambridge, Ma. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
---Anderson | | 14. MOTHER'S MAIDEN NAME
Daisy Oram | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Emory E. Keller, 1338 Glyndon Ave | |
| 18. 4221 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
arterioventricular CVD. | | CAUSE OF DEATH
(A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
yes. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from about 1960 to July 11, 1965 , that (I) (we) last saw the deceased alive on about May 19 60 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
S. Highstem | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7.12.65 | |
| 23C. PHYSICIAN'S NAME (Type)
G-HIGHSTEIN | | 23D. ADDRESS
888 W. Lombard St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/14/65 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park | |
| 24D. LOCATION (City, town, or county) (State)
Balto. 29, Ma | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS
Witzke F.D. 4101 Edmondson Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|--|--|--|--|---|------------------------------------|--|
| BIRTH NO. <u>3 6526808</u> | | | | | CERTIFICATE OF DEATH | | Registered No. <u>65 7308</u> | | |
| 1. NAME OF DECEASED
(Type or Print) <u>MIRVIS, HARRY WOLF</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>7-13-65</u> <u>11:40</u> P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>Sinai Hospital</u>
<u>42 Baltimore, Md.</u> | | | | | A. STATE <u>Md.</u> B. COUNTY <u>15-10</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore, Md.</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
<u>4407 Garrison Blvd.</u> | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>MARRIED</u> | | 8. DATE OF BIRTH
<u>9-17-1883</u> | 9. AGE (In years last birthday)
<u>81</u> | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>GROCERY</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>RETAIL</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Lithuania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Abraham Mirvis</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>MINNA KIRSTEIN</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>MR. Julius Mirvis 3327 INGELSIDE AVE.</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
<u>331X I</u>
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH
(A) <u>CVA</u>
DUE TO
(B) <u>Respiratory Failure</u>
DUE TO
(C) _____ | | | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-11-65</u> 19 <u>65</u> to <u>7-13</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>7-13</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Leonard J. Hertzberg</u> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> Intern <input type="checkbox"/> | | | 23B. DATE SIGNED
<u>7/13/65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>LEONARD J. HERTZBERG</u> M.D. | | | | | 23D. ADDRESS
<u>SINAI HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>REMOVAL & BURIAL</u> | | 24B. DATE
<u>7/14/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>NEW YORK</u> | | 24D. LOCATION (City, town, or county) (State)
<u>NEW YORK, NEW YORK</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 14 1965</u> | | 25B. NAME OF REGISTRAR
<u>P. G. E. Talone</u> | | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Sol LEVINSON + Bros. Inc. 6010 REISTERSTOWN RD.</u> | | | | |

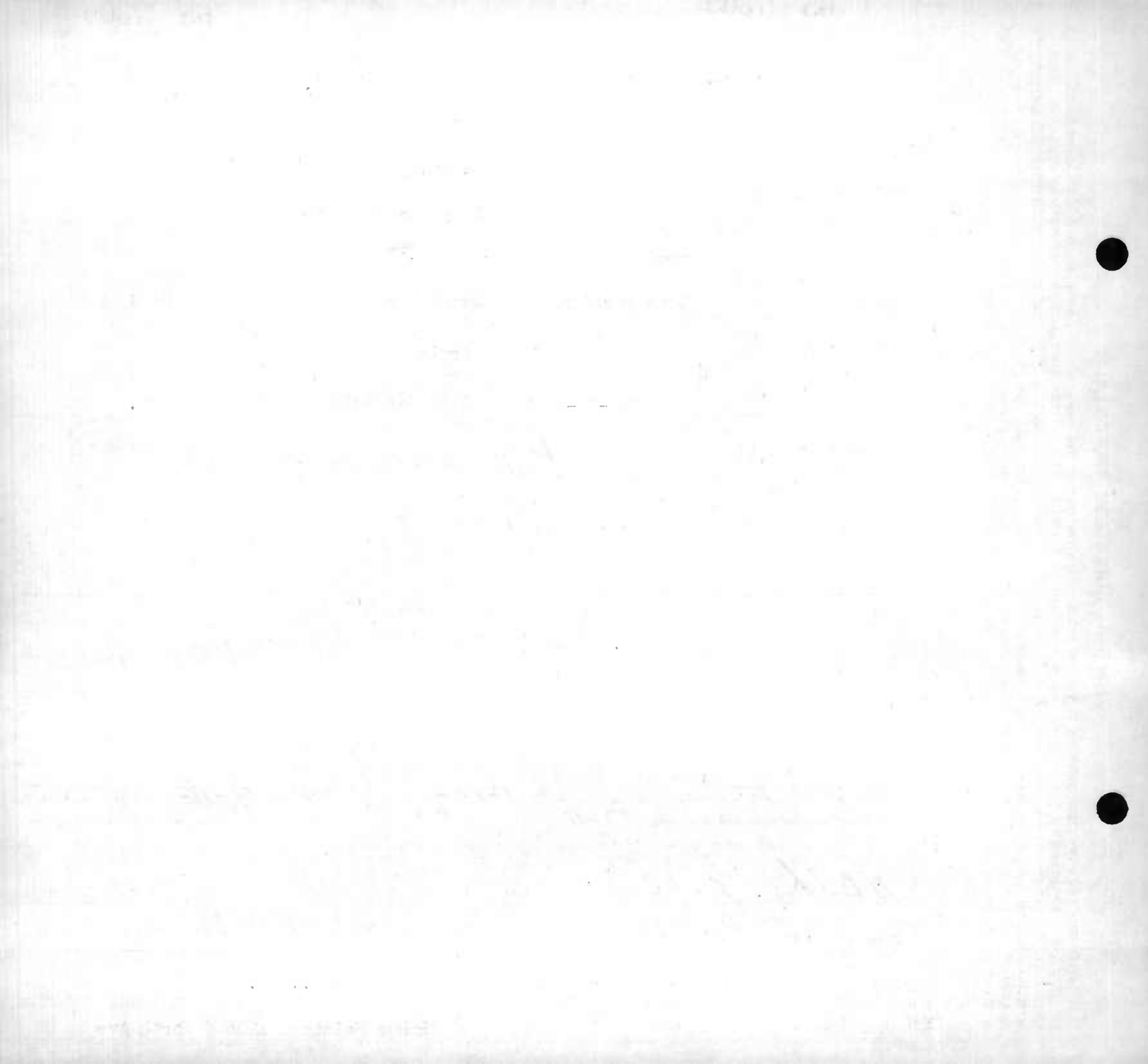


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7309 | | | | Baltimore City Health Department | | Registered No. 65 7309 | |
|--|---------------------|---|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) William Smith | | | | 2. DATE AND HOUR OF DEATH
July 11, 1965 5^{PM} A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1005 McKean Ave | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md
B. COUNTY 16-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1005 McKean Ave | | | |
| 5. SEX
M | 6. RACE
C | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
June 19, 1895 | | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
South Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Charles Smith | | | | 14. MOTHER'S MAIDEN NAME
Carrie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
217-07-9987 | | 17. INFORMANT
Lille Mae Smith 1005 McKean Ave. | | | |
| 18. 4 22 1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ARTERIOSCLEROSIS (GENERALIZED)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
SENILITY | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Renal Insufficiency
Myocardial Insufficiency | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-10-65 to 7-11-65 , that (I) (we) last saw the deceased alive on 7-11-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Gilbert L. Banfield | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Gilbert L. BANFIELD | | | | 23D. ADDRESS
722 N. FALTON AVE BALTO. 17, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/19/65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State)
Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
Adolphus Halstead 1206 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|-----------------------|--|--|--|--|
| BIRTH NO. 65 7310 | | 65 7310 | | Baltimore City Health Department | | Registered No. _____ | |
| M.E. CASE NO. 1. NAME OF DECEASED
(Type or Print) Katie Baylor | | | | 2. DATE AND HOUR OF DEATH
July 10, 1965 2:44 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 15-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2906 Reisterstown Road | | | |
| 5. SEX
F | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
? | 9. AGE (In years last birthday)
92 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Morgan | | | | 14. MOTHER'S MAIDEN NAME
Katie Morgan | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 6. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Edward Baylor 2906 Reisterstown Rd | | ADDRESS Son | |
| 18. 570.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Intestinal Obstruction
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 31, 1965 to July 10, 1965, that (I) (we) last saw the deceased alive on July 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J. Malabrigo | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 12, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Joel A. Malabrigo | | | | 23D. ADDRESS
1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
July 14, 1965 | | 24C. NAME OF CEMETERY or CREMATORY
Cathartes Memorial Park | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | 25C. FUNERAL DIRECTOR
V. Brooks Ruggold | | ADDRESS
14637, Carey St | |

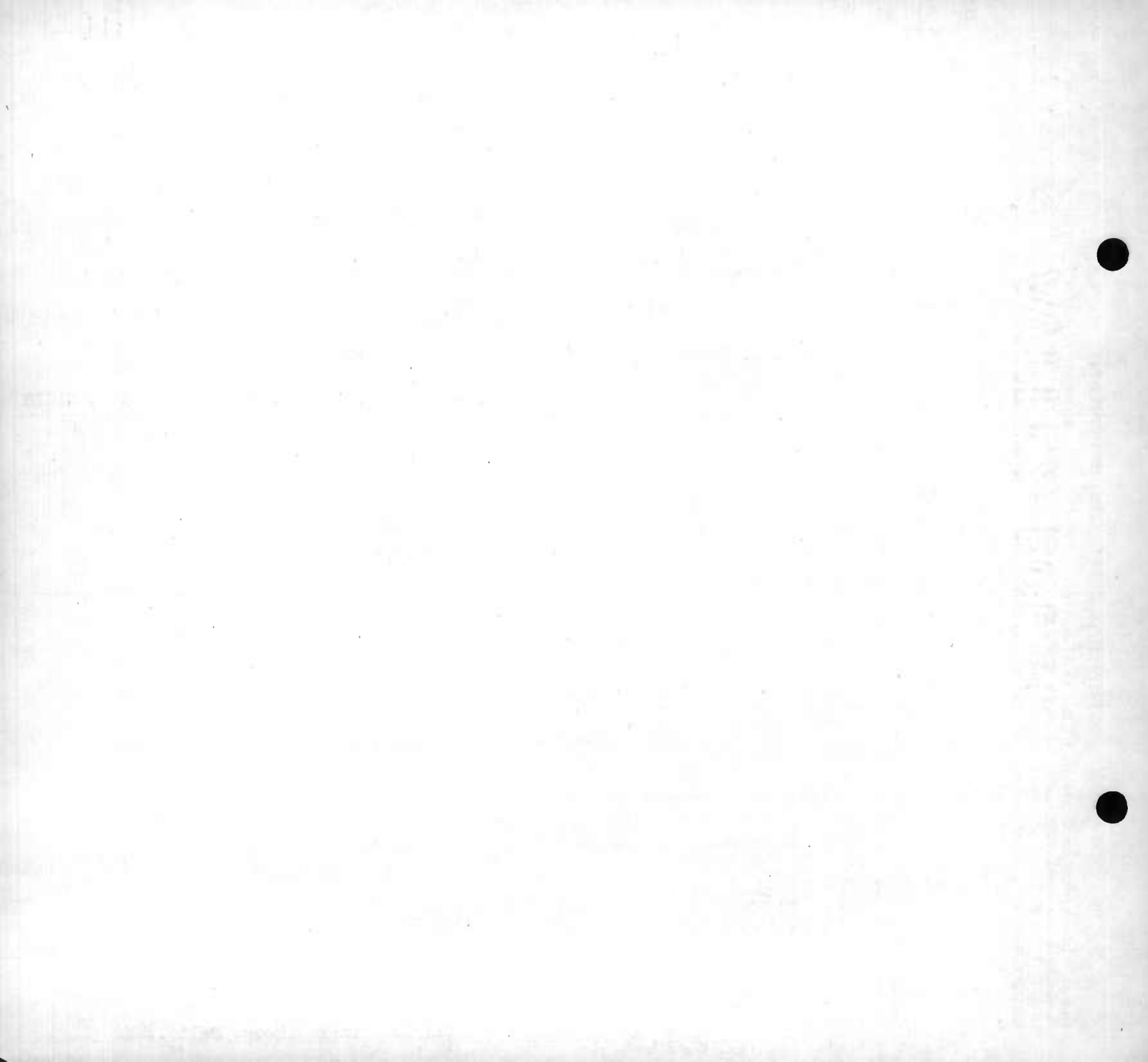
Richard O. Bantrol

W. B. Bantrol

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 7311 | |
|--|---------|---|------------------|---|--|--|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | CARRIE J. PEUSCH | | 12 July, 1965 5:20 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 5610 Belair Rd. | | | | Md. 9-06 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 2798 Tivoly Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| Female | White | single | June 6, 1877 | 88 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| saleslady | | retail | | Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Frederick G. E. Peusch | | | | Caroline Kellner | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| no | | | | Frederick J. Peusch, 2798 Tivoly Ave. | | 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | malnutrition senility | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 29 1965 to July 12 1965, that (I) (we) last saw the deceased alive on July 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Walter A. Anderson | | | | July 12-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| W. A. Anderson | | | | 3001 Shannon Dr. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| burial | | 7-14-65 | | Loudon Park Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 14 1965 | | Robert E. Fisher | | Ullrich Funeral Home, Balto., Md | | | |

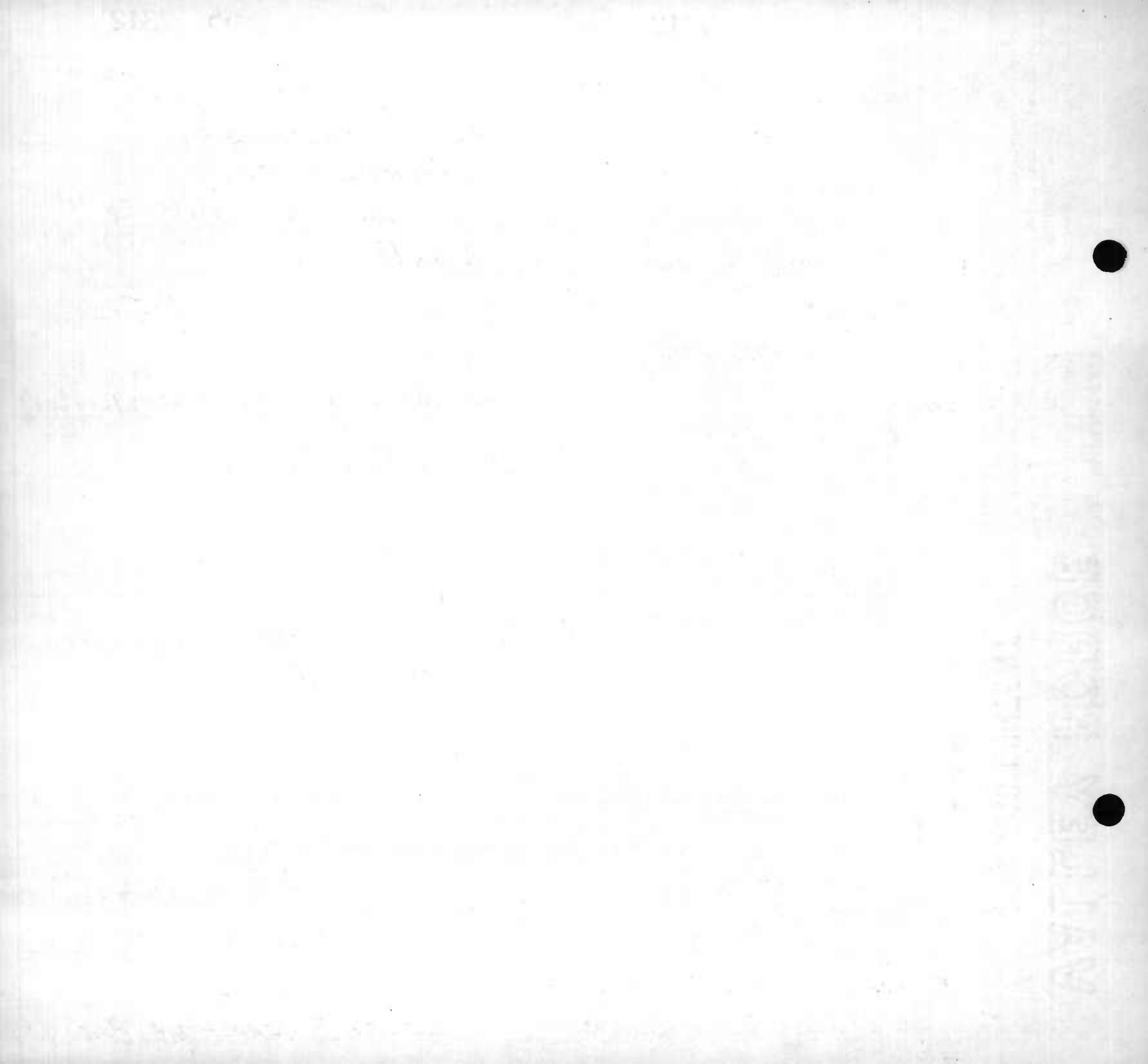


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7312 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7312 | |
|--|-------------------------|---|--|--|--|--|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Rebecca Winters | | | | 2. DATE AND HOUR OF DEATH
10 July 65 6:30 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

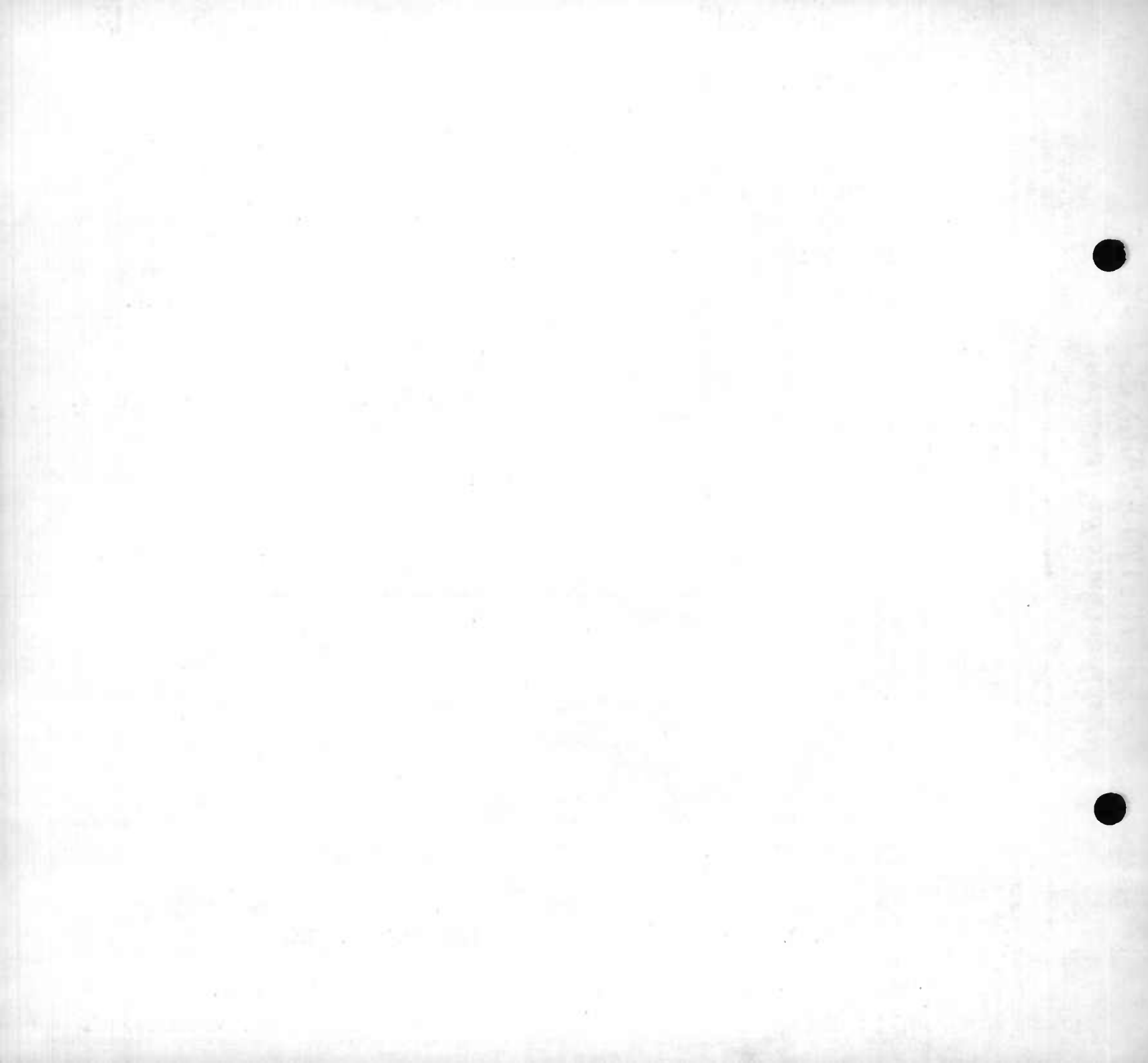
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
90 Fayette Convalescent Home | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD. B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) JARROWS POINT
D. STREET ADDRESS (If rural, give location) 53-00
702 F St 21219 Sp Pt | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
9 Jan 1896 | 9. AGE (In years last birthday)
69 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
AT HOME | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
UNKNOWN | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKN. | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs Irene Keiser | | |
| 18. 491 X 160.0
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
BRONCHOPNEUMONIA | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
5 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cirrhotic liver; Basal cell ca. nose | | | Several yrs | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1962 to 10 Jul 1965 , that (I) (we) last saw the deceased alive on 10 Jul 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
J. Hulla | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
10 Jul 65 | |
| 23C. PHYSICIAN'S NAME (Type)
J. Hulla | | | | 23D. ADDRESS
M.D. 2214 E Fayette St 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7-13-65 | | 24C. NAME of CEMETERY or CREMATORY
BALTIMORE CEMETERY | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
CLERICH FUNERAL HOME, BALTO. MD. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

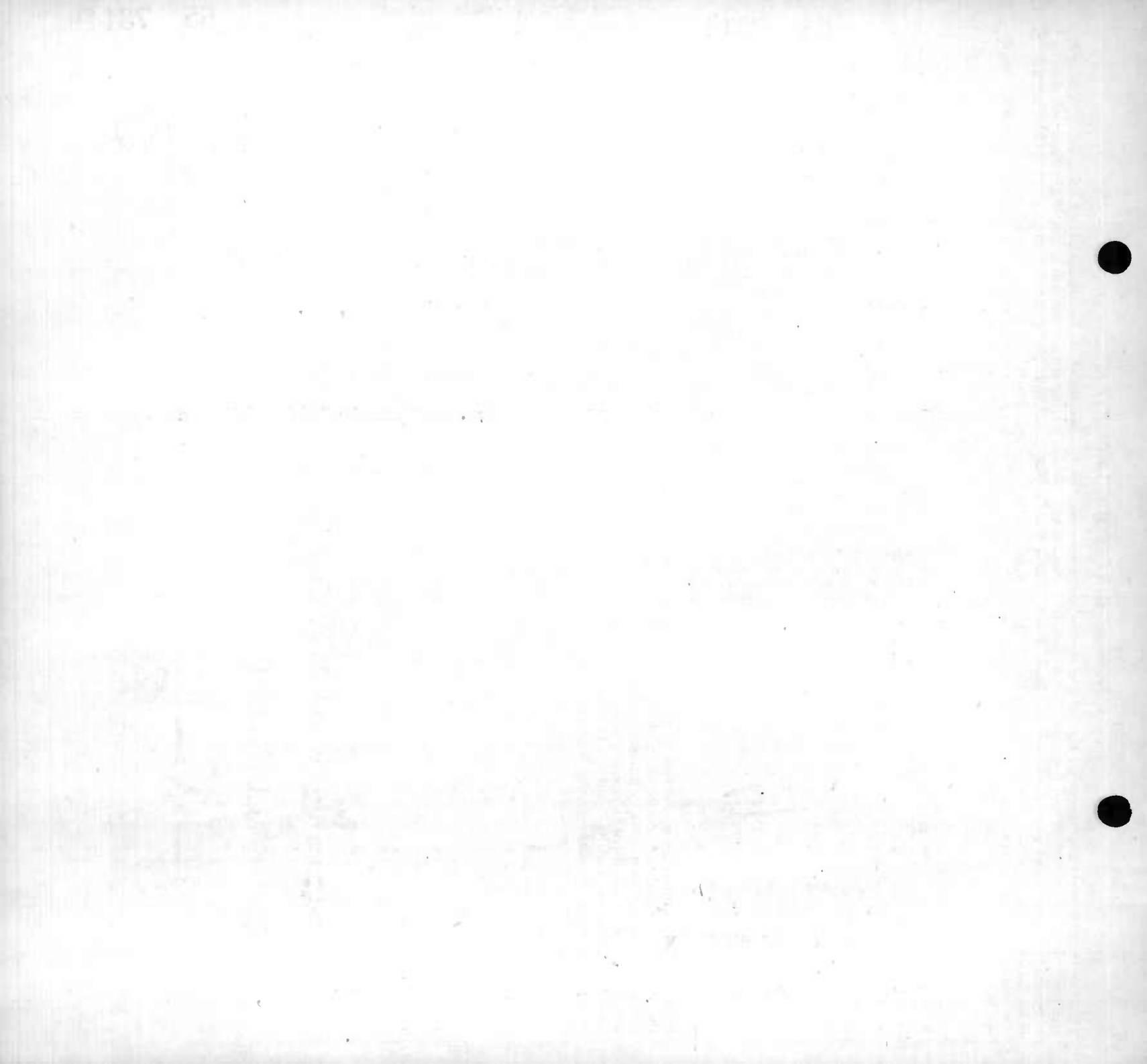
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Baltimore City Health Department | |
|---|--|--|--|--|--|
| 65 7313 | | | | 65 7313 | |
| BIRTH NO. | | | | Registered No. | |
| M.E. CASE NO. | | | | 1130 M. | |
| 1. NAME OF DECEASED
(Type or Print) EMMA J. SUTTON | | | | 2. DATE AND HOUR OF DEATH
11 July, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Garrison Nursing Home
Duval and Walbrook | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| D. STREET ADDRESS (If rural, give location)
809 N. Castle St. | | | | E. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| 5. SEX
Female | | 6. RACE
White | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | |
| 8. DATE OF BIRTH
22 July 1898 | | 9. AGE (In years last birthday)
66 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Edward N. Sutton, 649A Turkey Point Rd. | | ADDRESS
21221 | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Central arteriosclerosis
stroke
shakes
anemia
generalized arteriosclerosis
hypertension | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1964 to July 1965 , that (I) (we) last saw the deceased alive on July 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
M. P. Byerly | | | | 23B. DATE SIGNED
7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type)
M. P. Byerly | | | | 23D. ADDRESS
5820 York Rd. 21212 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
burial | | 24B. DATE
7-14-65 | | 24C. NAME of CEMETERY or CREMATORY
Baltimore Cemetery | |
| 24D. LOCATION
Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 24F. NAME OF REGISTRAR
Robert E. Farley, M.D. | |
| 24G. FUNERAL DIRECTOR
Ullrich Funeral Home, Baltimore, Md. | | 24H. ADDRESS | | 24I. DATE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

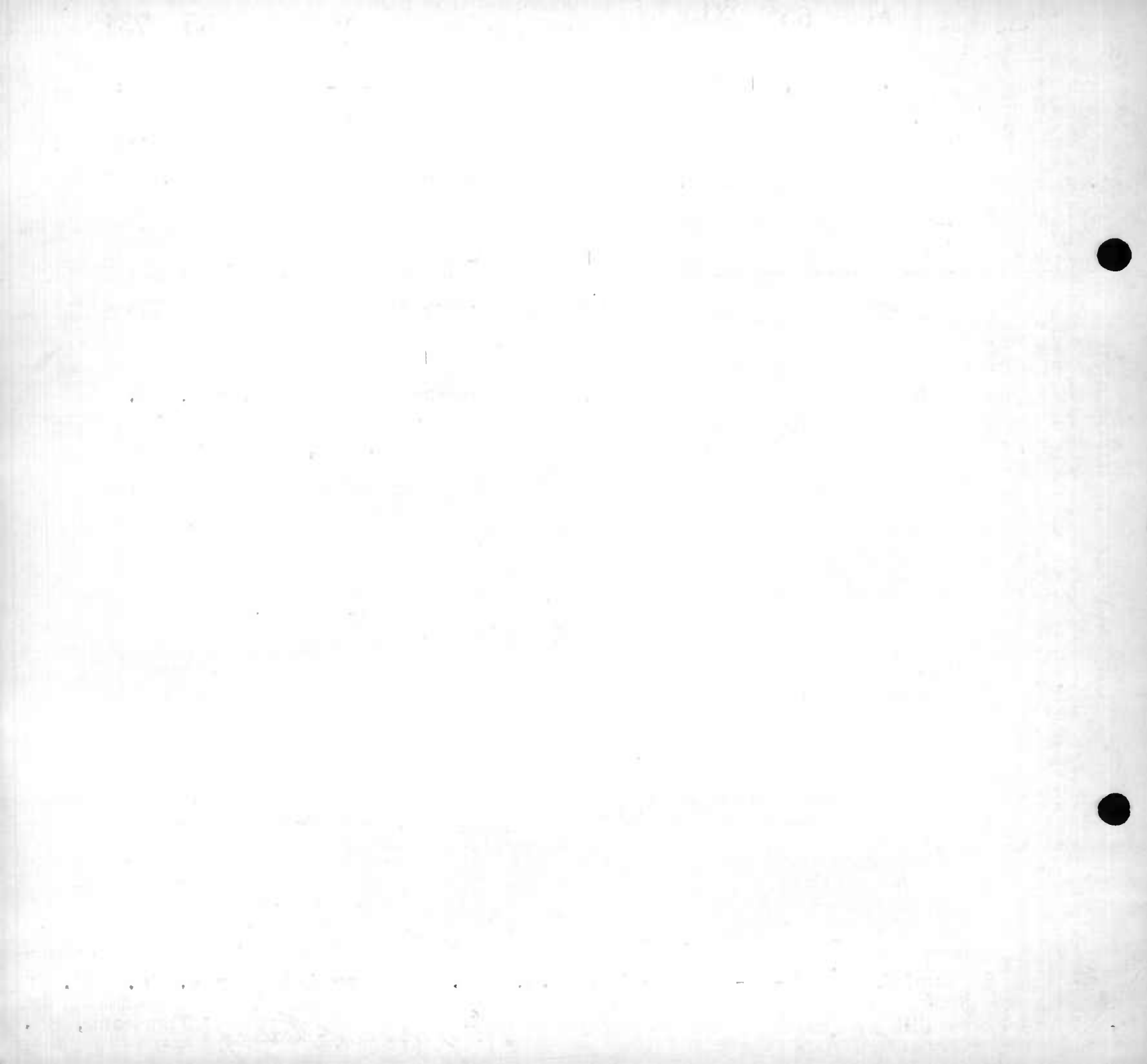
| BIRTH NO. 65 7314 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7314 | |
|---|-------------------------|---|--------------------------------------|--|------------------------------|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Servetus Coker</i> | | | | 2. DATE AND HOUR OF DEATH
<i>7/11/65</i> <i>6:00 PM</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>46 Lutheran Hospital</i> | | | | A. STATE <i>Maryland</i> B. COUNTY <i>15-02</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give Township)
<i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>1522-McKean Ave.</i> | | | |
| 5. SEX
<i>Fe</i> | 6. RACE
<i>Negro</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>widowed</i> | 8. DATE OF BIRTH
<i>3/14/1900</i> | 9. AGE (In years lost birthday)
<i>65</i> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>?</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Charlottesville, Va.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>?</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>?</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT - ADDRESS
<i>Mrs. Hester Winfield 1536 McKean Avenue</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>331X1</i> | | | | CAUSE OF DEATH
(A) <i>Cerebrovascular Accident</i>
DUE TO
(B) <i>Cerebral Hemorrhage</i>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>12 hrs.</i>
<i>12 hrs.</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>II</i> | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>July 11</u> , 19 <u>65</u> to <u>July 11</u> , 19 <u>65</u> , that (II) <u>(we)</u> last saw the deceased alive on <u>July 11</u> , 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Robert C. Blackmon</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>7/11/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
ROBERT BLACKMON | | | | 23D. ADDRESS
<i>Lutheran Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7/15/65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Mt. Auburn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 14 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Faldut</i> | | 25C. FUNERAL DIRECTOR
<i>Charles R. Law</i> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | Baltimore City Health Department | | | | Registered No. | | | |
|--|--|---------|--|--|--|------------------|--|--|--|--------------------------------|--|
| 65 7315 | | | | 7-11-65 | | | | 3:45 AM M. | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | HARNE, VICKY | | | | 7-11-65 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | 8. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | MARYLAND | | | | WASHINGTON | | | |
| THE JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | 71-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. If Under 1 Yr. Months Days | |
| F | | W | | NEVER MARRIED | | 2-9-62 | | 3 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| None | | | | | | | | Maryland | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| EUGENE HARNE | | | | BONNIE KUHN | | | | USA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| No | | | | None | | | | Eugene Harne Cavetown, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 176.9 | | | | Embryonal Rhabdomyosarcoma with CNS involvement | | | | 1 year | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | metastatic lesions to brain involving respiratory centers. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| None | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (A) (this hospital) attended the deceased from June 30 1965 to July 11 1965, that (A) (we) last saw the deceased alive on 3:30 PM July 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | | |
| Glen Wegner MD | | | | | | | | 7-11-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | |
| Glen Wegner | | | | | | | | JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | 7-13-65 | | | | Garfield U.B. Cem. | | | |
| 24D. LOCATION (City, town, or county) (State) | | | | 24E. DATE REC'D BY HEALTH DEPT. | | | | 24F. NAME OF REGISTRAR | | | |
| Garfield Fred. Co. Md. | | | | JUL 14 1965 | | | | Robert E. Starke, M.D. | | | |
| 24G. FUNERAL DIRECTOR | | | | 24H. ADDRESS | | | | 24I. DATE SIGNED | | | |
| Raymond K. Wagner | | | | Thurmont, Md. | | | | | | | |



1
I-200

65 7316

BALTIMORE CITY HEALTH DEPARTMENT

65 7316

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN E. IWASKO

2. DATE AND HOUR PRONOUNCED DEAD

7-11-65

4:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Del Mar

D. STREET ADDRESS (If rural, give location)

210 Maryland Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Oct. 16, 1931

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Aircraft

11. BIRTHPLACE (State or foreign country)

Chicago, Ill

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward B. Iwasko

14. MOTHER'S MAIDEN NAME

Anna Orłowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean

16. SOCIAL
SECURITY NO.

324-24-1723

17. INFORMANT

Betina Iwasko

ADDRESS

210 Md. Ave.

Delmar, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Intersection U.S. Rte 13
and Delaware Rts 41921D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) 6:45
5 29 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7-12-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-14-65

23C. NAME of CEMETERY or CREMATOR

St. Stephens

23D. LOCATION

(City, town, or county)

Delmar, Del.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUL 14 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Charles W. Gansel

ADDRESS

Delmar, Del.

WATER POLICE

Oct. 1, 1921

Chicago, Ill.

John J. Connelley

110

Connelley, John J.

110

Connelley, John J.

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Connelley, John J.

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Connelley, John J.

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Connelley, John J.

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Connelley, John J.

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Connelley, John J.

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Connelley, John J.

BIRTH NO. 65 7317 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7317

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) SUSIE DIXON 2. DATE AND HOUR PRONOUNCED DEAD
9 July 1965 8:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

46 Lutheran HospitalBaltimore

D. STREET ADDRESS (If rural, give location)

3912 Gwynns Falls Pkwy.

5. SEX

female

6. RACE

negro7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

May 12, 18729. AGE (In years
last birthday)93If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

? Redmon15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)No16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Hassie Dixon 3912 Gwynn Falls Pkwy

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/6523A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

7-13-65

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 14 1965Robert E. FisherThe Morton and Dyett Fun'l Home Inc.
1701-31 Laurens Street 21217

1317

WALLACE & GORRIGER

HAS CONTENT

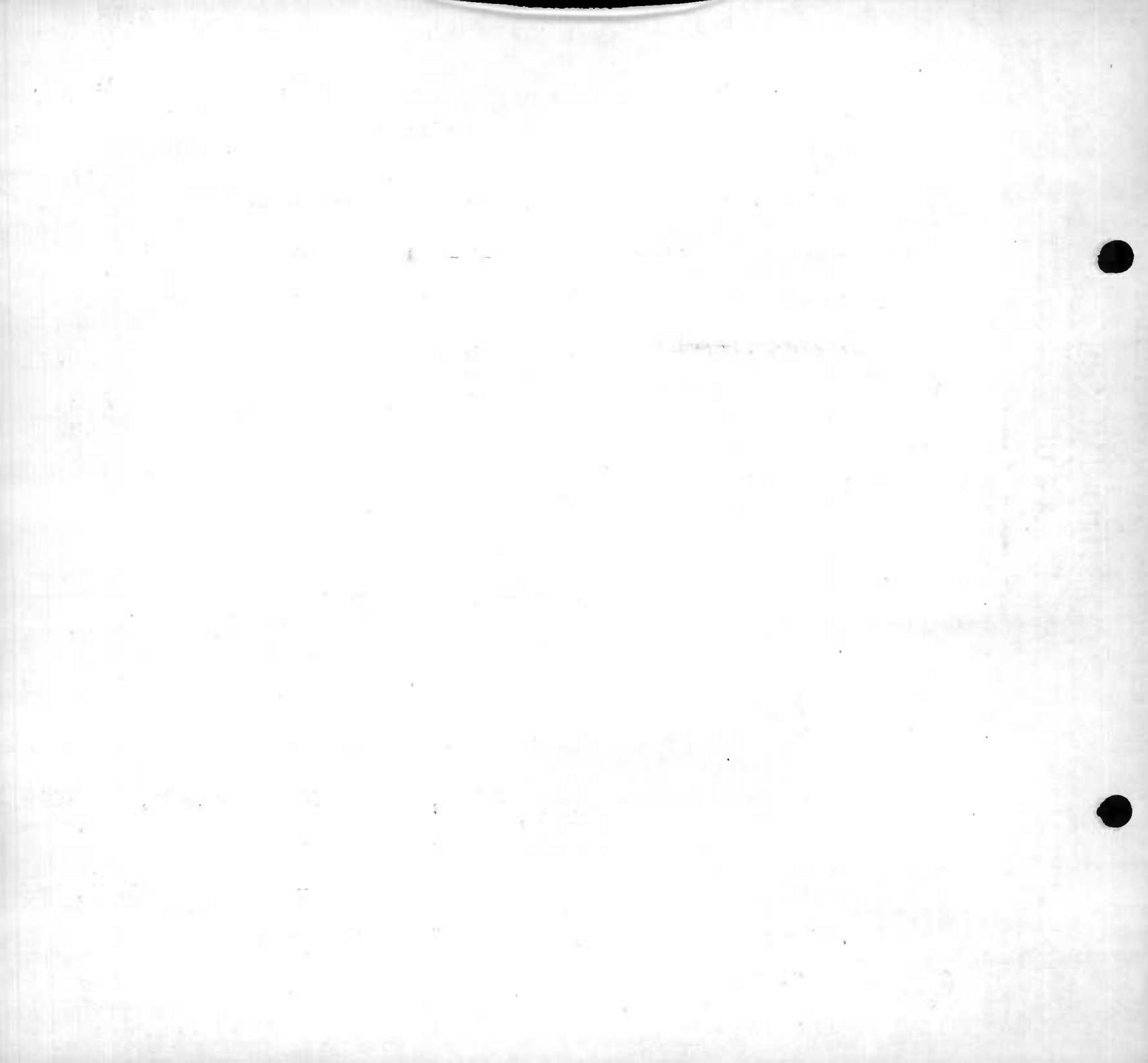
1000

Griffin

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

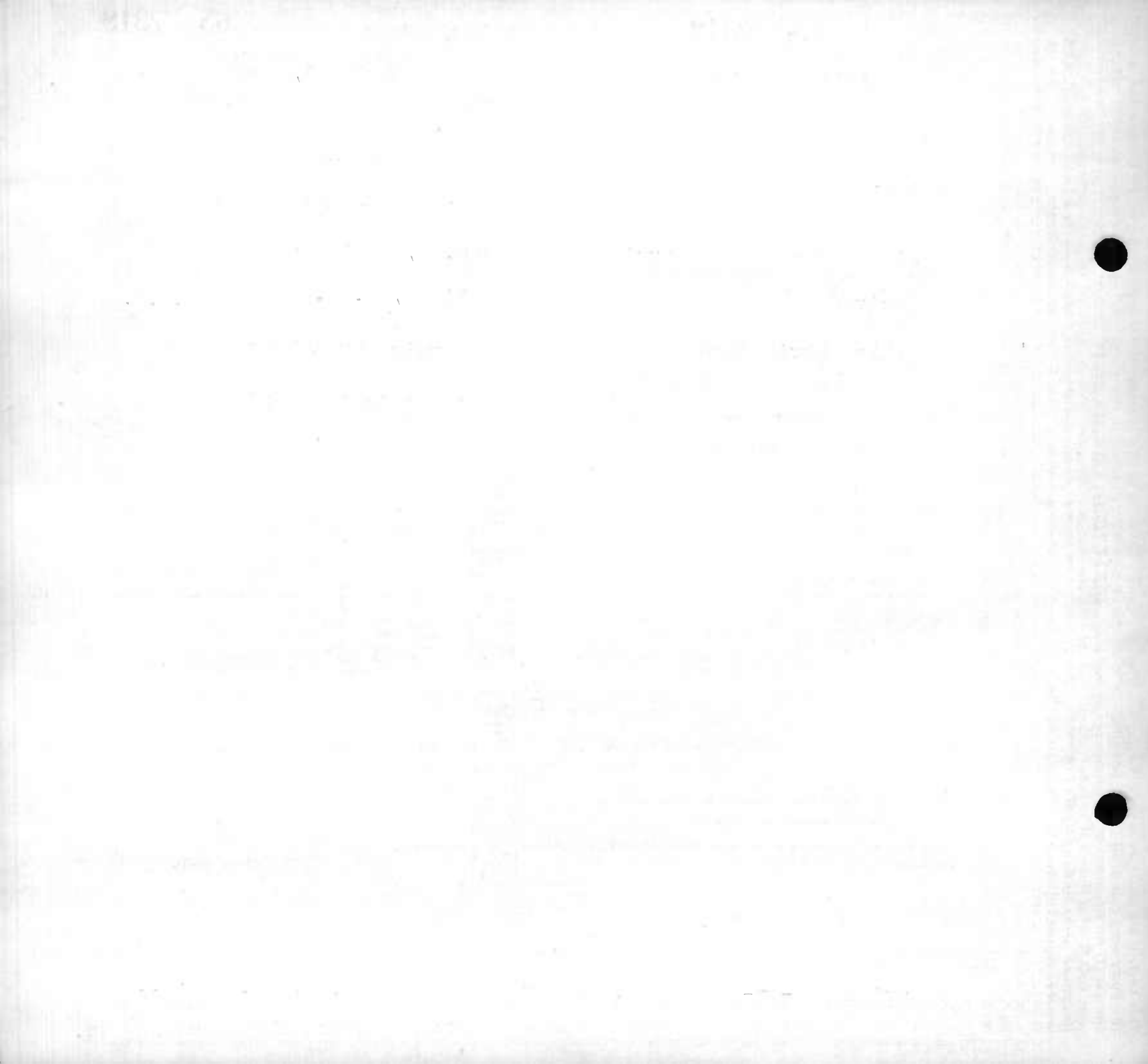
| BIRTH NO. 65 7318 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7318 | |
|--|------------------|--|-----------------------------------|---|--|--|-------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Ella Johnson | | | | 2. DATE AND HOUR OF DEATH
July 13, 1965 1:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1415 Division Street
Baltimore, Maryland | | | | A. STATE Maryland
B. COUNTY 14-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1729 Druid Hill Avenue | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
2-17-1901 | 9. AGE (In years lost birthday)
64 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
James. Hall | | | 14. MOTHER'S MAIDEN NAME
W. K. | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
W. Johnson 1729 Druid Hill Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Sudden severe chocolate hypocalcemia.
DUE TO
(B) H C VD + marked arteriosclerosis
DUE TO
(C) unilateral (left) kidney atrophy. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 4, 1965 to July 13, 1965, that (I) (we) last saw the deceased alive on July 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
[Signature] | | | | | | 23B. DATE SIGNED
July 13, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
A. Rigaus | | | | 23D. ADDRESS
M.D. 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-17-65 | | 24C. NAME of CEMETERY or CREMATORY
MT. Auburn | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
Morton + Dyett | | ADDRESS
1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|----------------------------------|--|---|
| BIRTH NO. 65 7319 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7319 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Willis Strickland | | 2. DATE AND HOUR OF DEATH
July 13, 1965 | | 3:18 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY | | 9-08 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2102 Homewood Avenue | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
2102 Homewood Avenue | | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Jan. 1, 1893 | 9. AGE (In years last birthday)
72 | II Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Raleigh, N. C. | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Ashley Strickland | | 14. MOTHER'S MAIDEN NAME
Louise Mc Culler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Annie Strickland 2102 Homewood Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
DUE TO Coronary Disease | | CAUSE OF DEATH
(A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1 1962 to July 13 1965, that (I) (we) last saw the deceased alive on July 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Louis R. Johnson | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
Louis R. Johnson | | M.D. 301-8-4244 | | 23D. ADDRESS
Baltimore 1820 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-16-65 | | 24C. NAME of CEMETERY or CREMATORY
Mt. Calvary | |
| | | 24D. LOCATION (City, town, or county) (State)
A. A. Co. Md.. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
R. B. E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS
Morton & Dyett 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

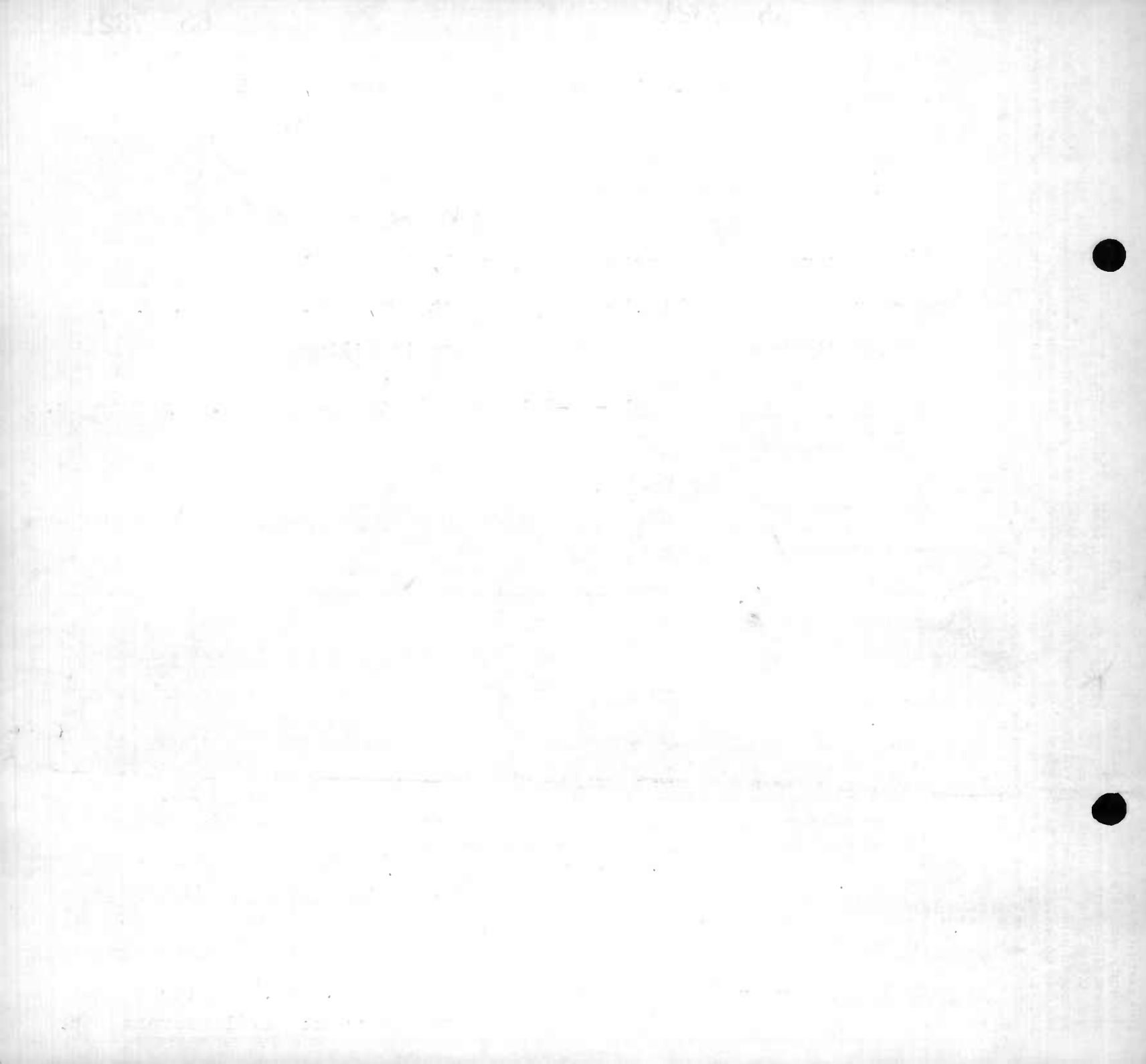
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|-----------------------------------|--|---|--|--|--|--|
| BIRTH NO.
65 7320 | | CERTIFICATE OF DEATH | | | | Registered No. 65 7320 | | | |
| 1. NAME OF DECEASED
(Type or Print) EDWARD DOWNS | | | | | 2. DATE AND HOUR OF DEATH
7-11-65 9 PM M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Lincoln Memorial Nur. Home
9027 N. Carey St | | | | | A. STATE
Md.
B. COUNTY
18-02 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
27 N. Carey | | | | |
| 5. SEX
Male | 6. RACE
negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
UNK. | 9. AGE (in years lost birthday)
81 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Labourer | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
UNK. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
UNK. | | | | 14. MOTHER'S MAIDEN NAME
UNK. | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNK. | | | | 16. SOCIAL SECURITY NO.
217-097810 | | 17. INFORMANT
MARY Pinkney ADDRESS
236 N. Arlington Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Blind
Syphilis CNS | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) Chronic
syphilis | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
2 yrs. chronic | | | | | INTERVAL BETWEEN ONSET AND DEATH
? | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1964 to July 11-1965 . that (I) (we) last saw the deceased alive on July 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
M. Johnson M.D. | | | | | 23B. DATE SIGNED
7-11-65 | | | 23C. PHYSICIAN'S NAME (Type)
M. Johnson M.D. | |
| 23D. ADDRESS
403 Medway B | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7-13-65 | | 24C. NAME OF CEMETERY or CREMATORY
MT. CALVARY | | | 24D. LOCATION (City, town, or county) (State)
A.A. Co. Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
R. E. F. F. | | | 25C. FUNERAL DIRECTOR
MOATON + DYKETT, F.H. ADDRESS | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7321 | |
| BIRTH NO. 65 7321 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED
(Type or Print) Booker T. Billups | | July 13, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
46 Lutheran Hospital | | A. STATE MD B. COUNTY 20-22 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO MD | |
| | | D. STREET ADDRESS (If rural, give location)
2822 W. FRANKLIN ST | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Jan 1, 1914 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY
Shipping | 9. AGE (In years last birthday)
51 |
| 13. FATHER'S NAME
Walter Billups | | 11. BIRTHPLACE (State or foreign country)
Matthews, Va. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes WW II | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 16. SOCIAL SECURITY NO.
218-07-5818 | | 14. MOTHER'S MAIDEN NAME
Sannie Billups | |
| 17. INFORMANT
Rachel Billups | | ADDRESS
2622 W. Franklin St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Myocarditis | | INTERVAL BETWEEN ONSET AND DEATH
Unknown | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Arteriosclerosis & hypertension | | (B) DUE TO
Unknown | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | |
| 19A. DATE OF OPERATION
7-26-65 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-26-65 to 7-12-65 , and that (I) (we) last saw the deceased alive on 7-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Frank A. Saunders | | 23B. DATE SIGNED
7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type)
FRANK A SAUNDERS | | 23D. ADDRESS
1029 N. Stucker St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7-16-65 | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | 24D. LOCATION (City, town, or county) (State)
Balto. City |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | |
| | | 25C. FUNERAL DIRECTOR ADDRESS
Morton & Dyett 1701 Laurens St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. |
|---|--|--|---|------------------------------------|
| BIRTH NO.
65 7322 | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| Condon, Sister Josepha (Margaret Rose) | | July 12, 1965 3:50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| X 6420 Reisterstown Road
FULL NAME OF (If not in hospital or institution, give street
HOSPITAL OR address or location)
INSTITUTION | | A. STATE B. COUNTY
Maryland Baltimore 28-41 | | |
| The Seton Psychiatric Institute | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| | | D. STREET ADDRESS (If rural, give location)
4000 Forest Hill Road - 21207 | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) |
| Female | White | never married | Sept. 25, 1892 | 72 |
| 10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | |
| Teacher | | School | Deerfield, New York | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF
WHAT COUNTRY? | |
| Pierre Condon, Deerfield, N.Y. | | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL
SECURITY NO. | 17. INFORMANT ADDRESS | |
| No | | none | Sister Mary Louise, Adm., 4000 Forest Hill Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.) | | CAUSE OF DEATH | | |
| 420.1 I | | (A) Coronary occlusion 1 day | | |
| ANTECEDENT CAUSES | | (B) General arteriosclerosis 8 years | | |
| DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last. | | (C) | | |
| II | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | no | | |
| 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) | 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | |
| 21D. TIME
OF INJURY
(APPROX.) | 21E. INJURY OCCURRED
While At <input type="checkbox"/> Not While
Work At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 18 19 57 to July 12, 19 65,
that (I) (we) last saw the deceased alive on July 8, 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| Damian P. Alagia | | | | July 12, 1965 |
| 23C. PHYSICIAN'S
NAME (Type) | | 23D. ADDRESS | | |
| Damian P. Alagia | | M.D. 3326 Judson Ave | | |
| 24A. BURIAL CREMATION,
REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
| burial | July 14-65 | St. Joseph's | Emmitsburgh, Frederick Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | |
| JUL 14 1965 | Robert E. Faley M.D. | Stewart & Mowen Co. 108-W-North-Av. 21201 | | |

65 7323

BALTIMORE CITY HEALTH DEPARTMENT

65 7323

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE CLARK

2. DATE AND HOUR PRONOUNCED DEAD

7/12/65 10:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

442 E. 22nd St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widower

8. DATE OF BIRTH

Aug. 29, 1900

9. AGE (In years
(last birthday))

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer - retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond County, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Clark

14. MOTHER'S MAIDEN NAME

Mary Burrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
218-01-7054

17. INFORMANT

ADDRESS

Mrs. Fannie Robinson 442 E. 22nd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-16-65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 14 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Marshall W. Jones, Jr. 1735 Harford Ave.

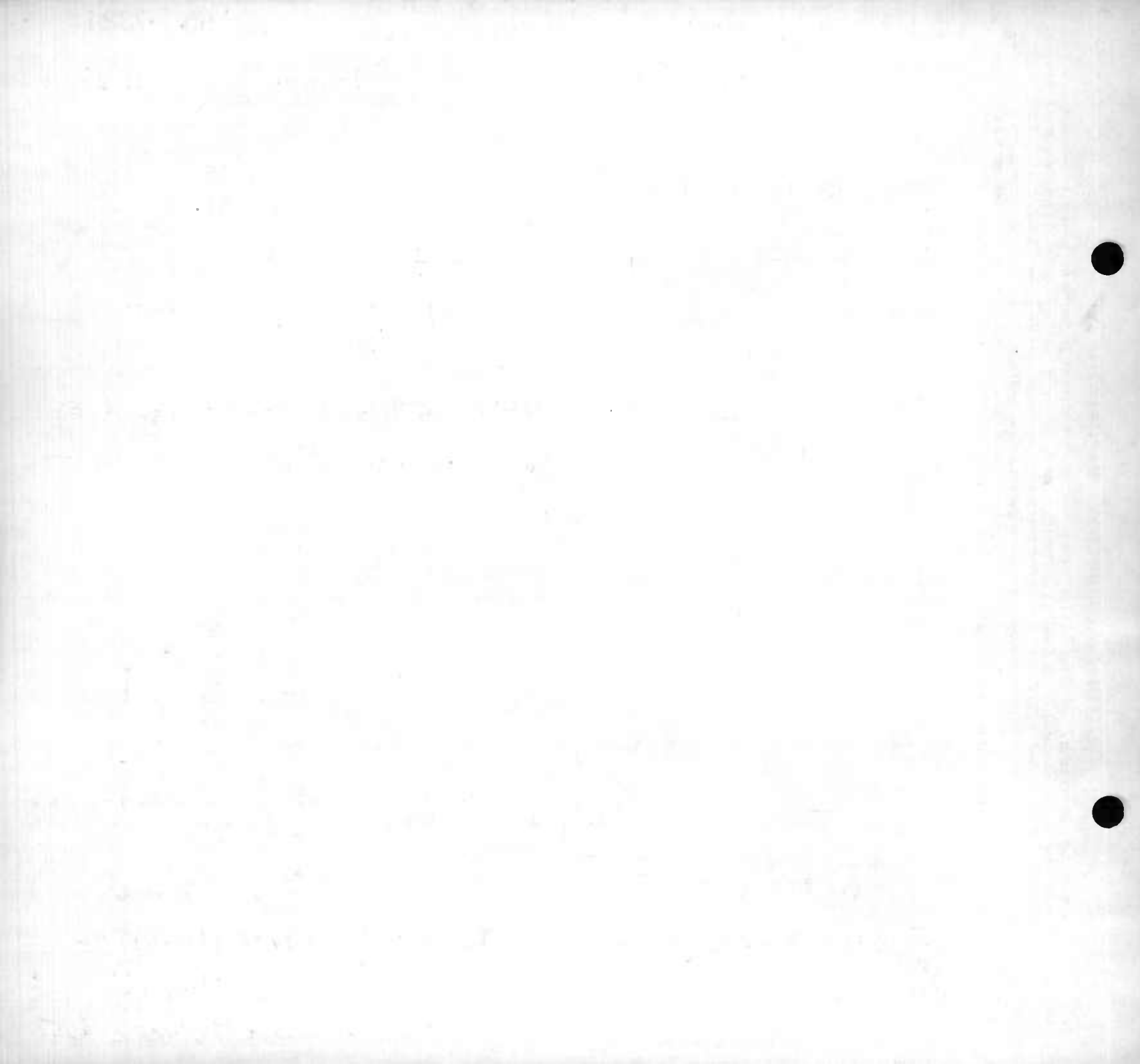
WILLIAM L. RICHMOND

REPORT OF THE
 BOARD OF
 DIRECTORS
 OF THE
 RICHMOND
 SAVINGS
 BANK
 FOR THE
 YEAR
 1887

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

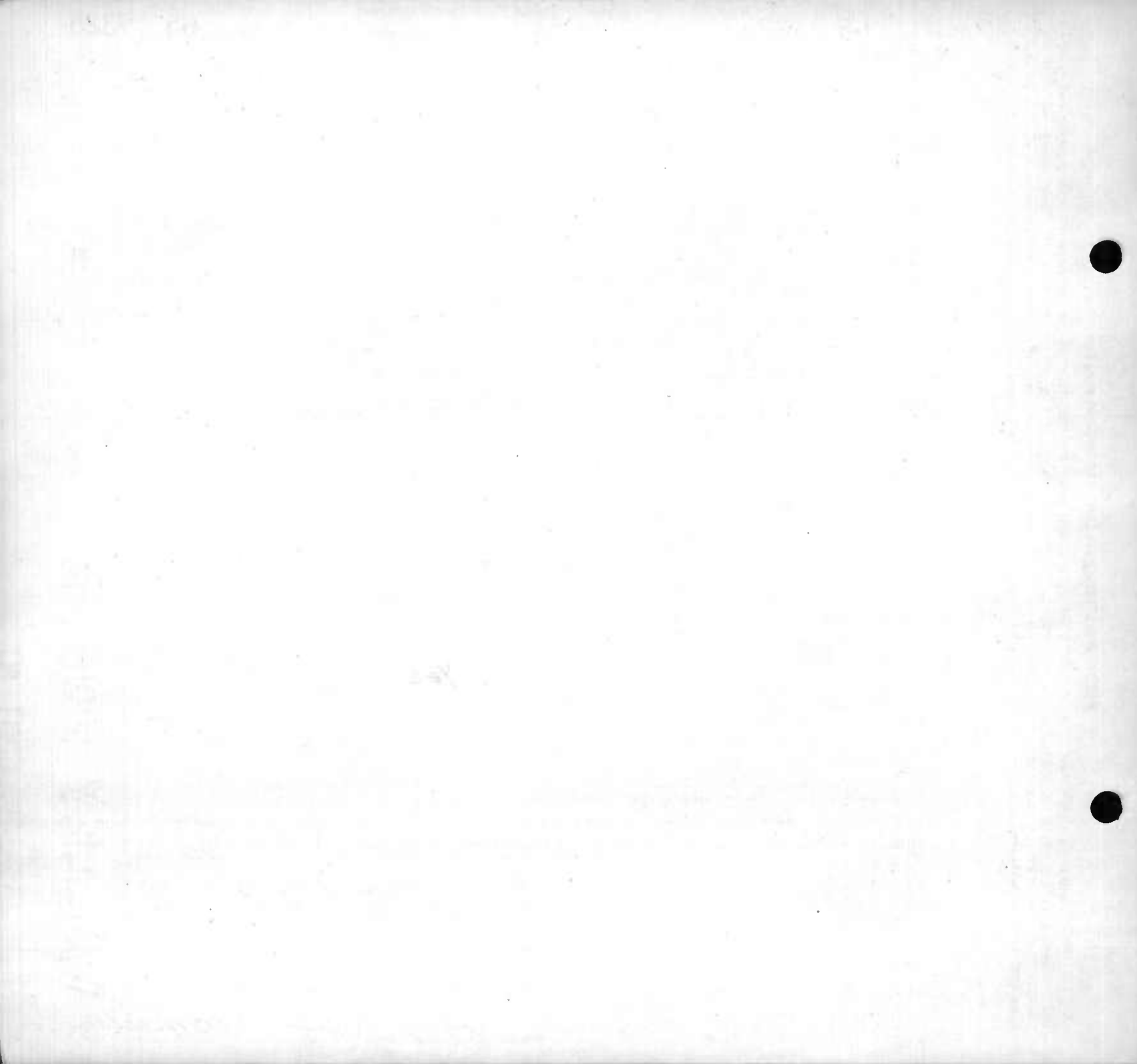
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------|--|---|--|---|
| BIRTH NO. | | 65 7324 | | 65 7324 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | EDWARD JAMES THORNTON | | 7-12-65 11:25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| JOHNS HOPKINS HOSPITAL | | MARYLAND 15-38 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE, 16 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2629 HILTON ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| MALE | COLORED | WIDOWER | 9-29-04 | 60 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| LABORER | | | Virginia | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| SAMUEL THORNTON | | | ANNA JONES | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 217-05-6312 | | Robert Thornton - 3424 Holmes Ave - | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 180 x I | | Carcinoma of bladder | | 4 yrs. | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | NONE | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1 19 65 to July 12 19 65, that (I) (we) last saw the deceased alive on July 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| J. Martin Lebowitz | | | | 7-12-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J. MARTIN LEBOWITZ | | JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 7-17-65 | | Mt. Auburn | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| BALTIMORE Maryland | | JUL 14 1965 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 14 1965 | | R. E. Farley | | MARSHALL W. JONES, JR. 1735 HARFORD AVE. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7325 | |
|---|-----------------------------|--|--|---|--|
| BIRTH NO. 65 7325 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print)
EDMONDS, Thomas | | | 2. DATE AND HOUR OF DEATH
7-12-65 2:25 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
LUTHERAN HOSPITAL of Maryland
46 | | | A. STATE MARYLAND
2406 PRESBURY ST. BALTO. MD | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 15-03 | | |
| | | | D. STREET ADDRESS (If rural, give location)
2406 PRESBURY ST. | | |
| 5. SEX
MALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9/11/1890 | 9. AGE (In years last birthday)
74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
- | | | 14. MOTHER'S MAIDEN NAME
- | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
218-10-0760 | 17. INFORMANT ADDRESS
Ruth Edmond 2406 Presbury St. | | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
HEMMORHAGE
(A) DUE TO
CARDIAC FAILURE
(B) DUE TO
CVA
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
10 Hrs. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-19 19 65 to 7-12 19 65 , that (I) (we) last saw the deceased alive on 7-12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Inia C. Espina M.D. M.D. | | | | 23B. DATE SIGNED
7-12-65 | |
| 23C. PHYSICIAN'S NAME (Type)
INIA C. ESPINA | | | | 23D. ADDRESS
Lutheran Hospital of Maryland M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7-16-65 | 24C. NAME OF CEMETERY or CREMATORY
Cavon Mm. PK. | | 24D. LOCATION (City, town, or county) (State)
Harwood, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fink | | 25C. FUNERAL DIRECTOR ADDRESS
George A. Kela 1348 N. Calhoun St | |

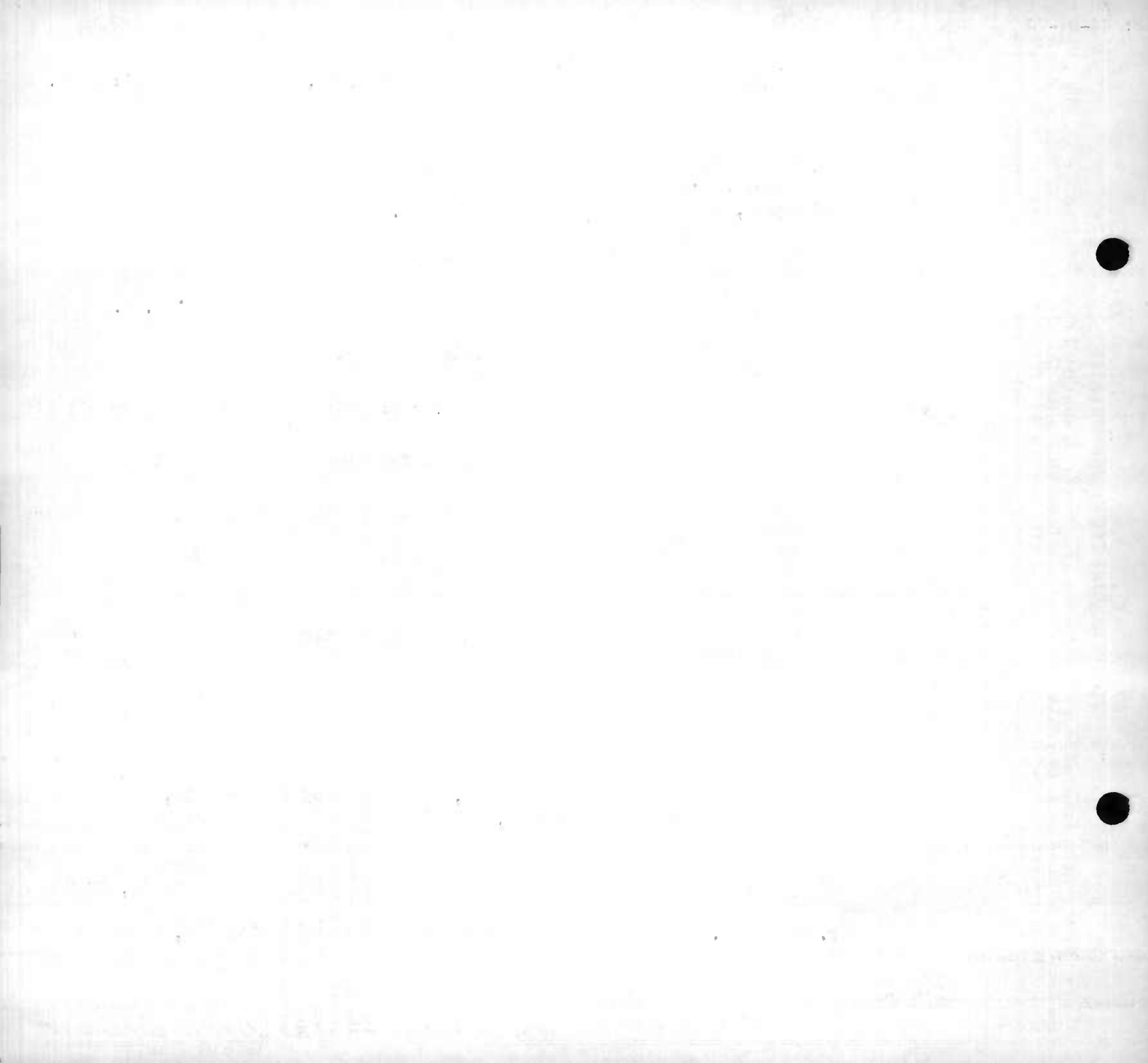


P 456

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 7326 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7326 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Ella Palmer | | July 11, 1965 | | 11:00 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY | |
| 31
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | 16-02 | |
| | | D. STREET ADDRESS (If rural, give location) | | 1526 1/2 Lanvale Street #21217 | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
9-21-83 | 9. AGE (In years last birthday)
81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Geo. Henry | | 14. MOTHER'S MAIDEN NAME
Alice Haskin | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH: 4940 Eastern Avenue #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)
420.1 I
Myocardial Infarction | | CAUSE OF DEATH
(A) DUE TO
Arteriosclerotic Cardio Vascular Disease | | INTERVAL BETWEEN ONSET AND DEATH
Instant | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
(C) | | Years | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Severe Rheumatoid Arthritis | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 6, 19 65 to July 11, 19 65, that (I) (we) last saw the deceased alive on July 11, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H. Rathbun | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 11, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Howard K. Rathbun | | 23D. ADDRESS
M.D. 4940 Eastern Avenue Baltimore, Maryland #24 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-15-65 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Mem. Pk. | |
| 24D. LOCATION (City, town, or county) (State)
Arbutus Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
George A. Nelson 1548 N. Calhoun St | |



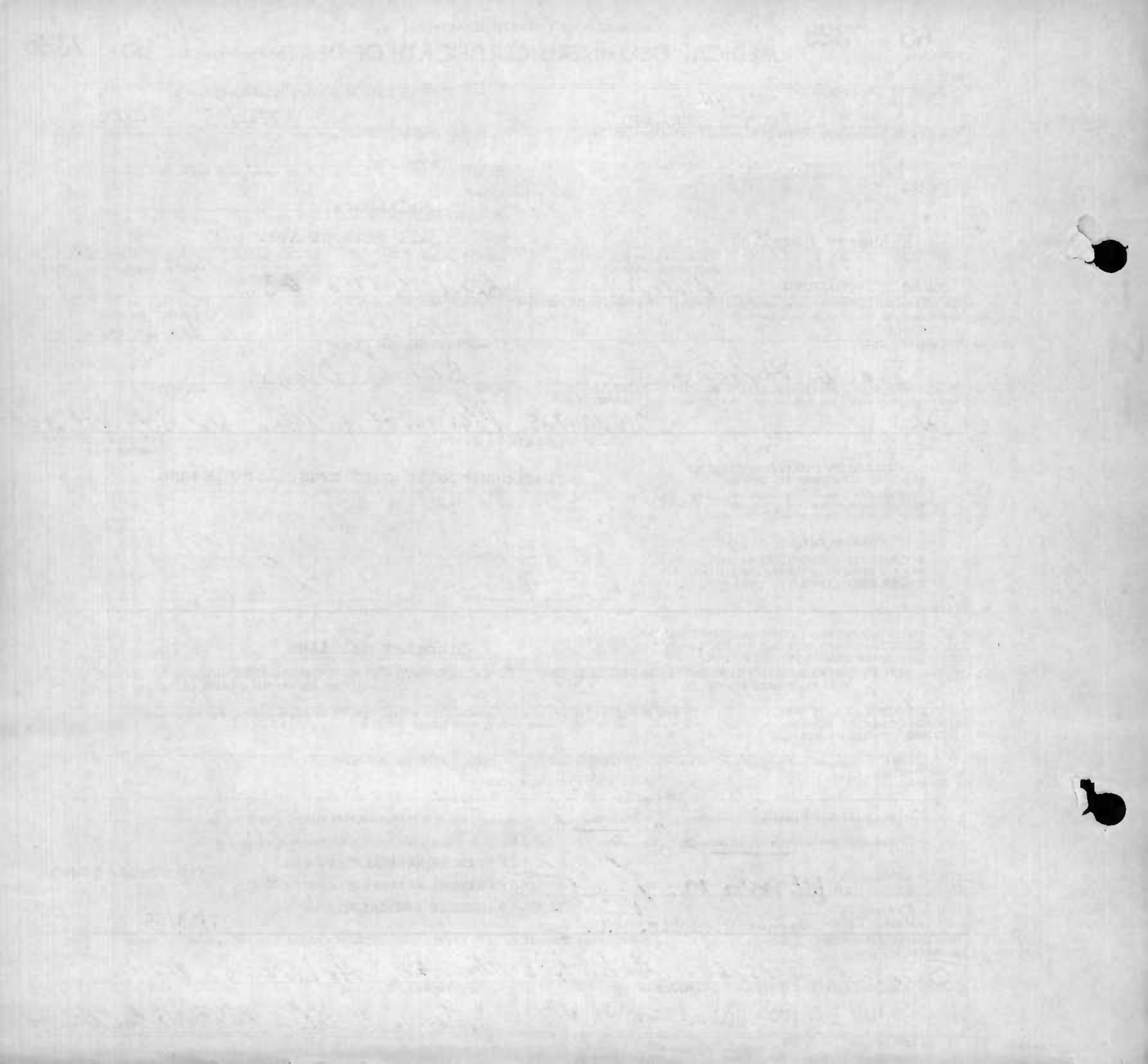
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7327 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7327 | |
|---|---------------------|--|---|---|--|---|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Rice Jesse</i> | | | | 2. DATE AND HOUR OF DEATH
<i>7/12/65</i> <i>8:50</i> A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>38 University Hospital</i> | | | | A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN. (If outside city limits, write RURAL and give township) | | | |
| | | | | <i>Baltimore</i> <i>21230</i> | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | |
| <i>2213 Brunst St</i> | | | | | | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>MARRIED</i> | 8. DATE OF BIRTH
<i>11/7/40</i> | 9. AGE (In years last birthday)
<i>24</i> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore Md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | |
| 13. FATHER'S NAME
<i>Mack Rice</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Allien Hawkins</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>212-36-0535</i> | | 17. INFORMANT
<i>Wife - Margaret Rice</i> | | |
| 18. <i>330X I</i> | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO
<i>Bleeding from ruptured cerebral aneurysm</i> | | | <i>18 days</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | | | |
| | | | (C) | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>6-25</i> 19 <i>65</i> to <i>7-12</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>7-12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Thavatchai Fuangvuthiran</i> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>7-12-65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>THAVATCHAI FUANGVUTHIRAN M.D.</i> | | | | 23D. ADDRESS
<i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7-16-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MT Auburn Cem.</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 14 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>George A. Kehr 1348 N. Calhoun St.</i> | | | |

1
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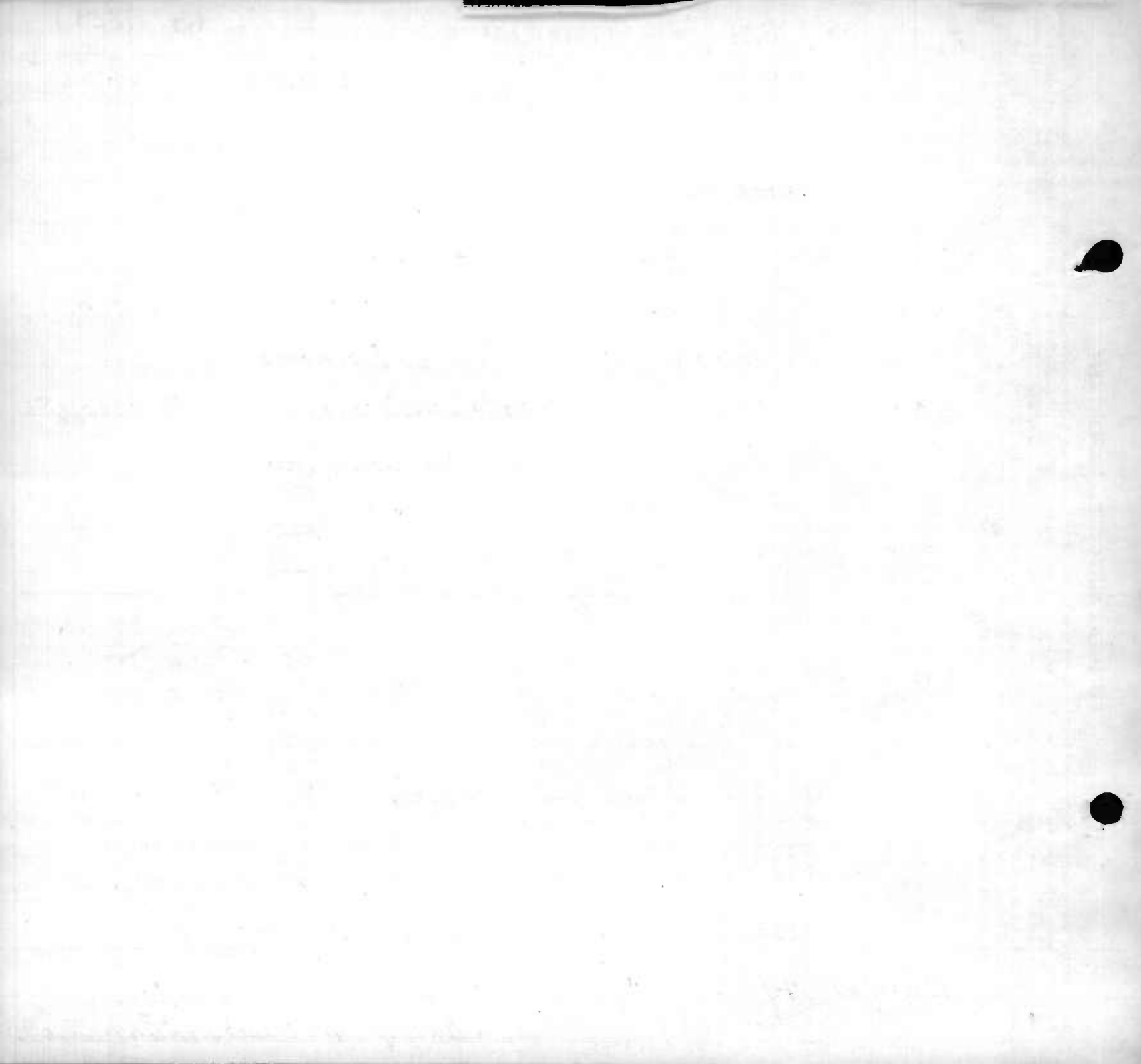
| | | | |
|--|---------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print)
WALTER HOLLAND | | 2. DATE AND HOUR PRONOUNCED DEAD
7/12/65 9:00 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
Lutheran Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 16-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3121 Belmont Ave. | |
| 5. SEX
male | 6. RACE
colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
April 4, 1902 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years)
63
If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min. |
| 13. FATHER'S NAME
Jacob Holland | | 14. MOTHER'S MAIDEN NAME
Sarah Diggs | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216-10-1729 | 17. INFORMANT
Margaret Holland
ADDRESS
3121 Belmont Ave |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Diabetes mellitus
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION
7-15-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
no |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
7-15-65 | |
| 23C. NAME OF CEMETERY or CREMATORY
Arbutus Mem. Pk. | | 23D. LOCATION (City, town, or county) (State)
Arbutus, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 24B. NAME OF REGISTRAR
Robert E. Farkas, M.D. | |
| 24C. FUNERAL DIRECTOR
George H. Kilar | | 24D. ADDRESS
1348 N. Calhoun St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7329 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7329 | |
|---|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| CRAFTON, CHARLIE | | | | July 11, 1965 | | 6:20 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| St. Joseph Hospital | | | | Maryland 10-01 | | | |
| 5. SEX Male | | | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 7-7-08-09 | | | | 9. AGE (In years lost birthday) 56 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | 11. BIRTHPLACE (State or foreign country) Prince Geo. Co., Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Eddie Crafton | | | |
| 14. MOTHER'S MAIDEN NAME Betty Edmond | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 213-09-3430 | | | | 17. INFORMANT Cordon Crafton 913 E. Preston St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Generalized carcinomatosis | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) None | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 29, 1965 to July 11, 1965, that (I) (we) last saw the deceased alive on July 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Benjamin del Carmen M.D. | | | | 23B. DATE SIGNED July 11, 1965 | | 23C. PHYSICIAN'S NAME (Type) Benjamin del Carmen M.D. | |
| 23D. ADDRESS 1400 N. Caroline Street - 21213 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-14-65 | | 24C. NAME OF CEMETERY or CREMATORY Arbustus Memorial PK Arbustus, Md. | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 14 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, MA | | 25C. FUNERAL DIRECTOR Randolph J. Collick 1412 E. Preston St. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|------------------------------------|--|---|
| BIRTH NO. 65 7330 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7330 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Wilbur Belt</u> | | 2. DATE AND HOUR OF DEATH
<u>7/12/65</u> <u>7:10 P</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>MARYLAND</u>
B. COUNTY <u>AA</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Millersville (Rural) 52-00</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>University of Maryland Hospital</u> | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>N</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>5/26/92</u> | 9. AGE (In years last birthday)
<u>73</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Construction Work</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Samuel Belt</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillie Thomas</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-72-9214</u> | | 17. INFORMANT
<u>Dr. Henry Sarontz</u> | |
| 18. <u>420.1 + 001X</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) <u>Myocardial Infarction</u>
DUE TO
(B) <u>ASCVD</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>14 days</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Silico-TB, CVA-①</u> | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
<u>None</u> | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
<u>None</u> | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
<u>None</u> | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-9</u> 19 <u>65</u> to <u>7-12</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Henry A. Sarontz</u> | | | | 23B. DATE SIGNED
<u>7-12-65</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Henry A. Sarontz</u> | | | | 23D. ADDRESS
<u>M.D.</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>7-16-65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Balto. National</u> | |
| 24D. LOCATION
<u>Balto. Md</u> | | 24E. NAME OF REGISTRAR
<u>Robert E. Talbot</u> | | 24F. FUNERAL DIRECTOR
<u>William Reese</u> | |
| 24G. DATE REC'D BY HEALTH DEPT.
<u>JUL 14 1965</u> | | 24H. NAME OF REGISTRAR
<u>Robert E. Talbot</u> | | 24I. FUNERAL DIRECTOR
<u>William Reese</u> | |
| 24J. ADDRESS
<u>Anna, Md.</u> | | 24K. ADDRESS
<u>Anna, Md.</u> | | 24L. ADDRESS
<u>Anna, Md.</u> | |

1

BIRTH NO. 65 7331 BALTIMORE CITY HEALTH DEPARTMENT MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7331

M.E. CASE NO. K-200

| | | | |
|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| THEODORE KESS | | 7/12/65 9:15 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE B. COUNTY | |
| St. Joseph Hospital | | Maryland | |
| 5. SEX | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | |
| male | | Baltimore | |
| 6. RACE | | D. STREET ADDRESS (If rural, give location) | |
| colored | | 1613 N. Broadway | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| married | | Nov. 24, 1892 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9. AGE (In years last birthday) | |
| Retired | | 72 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | Baltimore Md | |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George Kess | | U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 14. MOTHER'S MAIDEN NAME | |
| Yes WWI | | Essy Clara Kess | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | Katherine Brown same | |
| 18. CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUTION LAST. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| yes | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| | | | |
| 21C. WHERE DID INJURY OCCUR? | | 21D. TIME OF INJURY (APPROX.) | |
| (If in Baltimore City, give exact location) | | (Month) (Day) (Year) (Hour) | |
| | | | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER | |
| Werner U. Spitz, M.D. | | DATE SIGNED | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | |
| Burial | | 7-16-65 | |
| 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Balto. Nat. Cem. | | Balto. Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | |
| JUL 14 1965 | | Robert E. Farley | |
| 24C. FUNERAL DIRECTOR | | 24D. ADDRESS | |
| E. O. Wilson | | 1000 Broadway Ave. | |

VS 151-REV. 1/1/65

THE STATE OF NEW YORK

IN SENATE
January 1, 1901

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899

ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS
1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7332 | |
|--|---|---|---|---|---|
| BIRTH NO. 65 7332 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CHARLES EDWARD HASKINS | | 2. DATE AND HOUR OF DEATH
JULY 12, 1965 11:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
UNIV. OF MD. HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE OHIO
B. COUNTY V-32 | | | |
| CERTIFICATE CORRECTED 7-20-65 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
CANTON | | | |
| | | D. STREET ADDRESS (If rural, give location)
1041 WALNUT AVE. N.E. | | | |
| 5. SEX
M | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWER | 8. DATE OF BIRTH
12-12-1876 | 9. AGE (In years last birthday)
88 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
- (Ret.) | | 10B. KIND OF BUSINESS OR INDUSTRY
Park Manager | | 11. BIRTHPLACE (State or foreign country)
ARK. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
George William HASKINS | | 14. MOTHER'S MAIDEN NAME
Eliza Rowe | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
233-01-1581 | | 17. INFORMANT ADDRESS
305 MEDORA RD. LINTHICUM HEIGHTS, MD. | |
| 18. 443 X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) INTRAVENTRICULAR AND INTRACEREBRAL HEMORRHAGE
DUE TO
(B) SYSTEMIC HYPERTENSION
DUE TO
(C) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE | | INTERVAL BETWEEN ONSET AND DEATH
17 HOURS

OVER 20 YRS.

OVER 20 YRS. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9:40 PM 7-12-1965 to 11:30 PM 7-12-1965 , that (I) (we) last saw the deceased alive on 7-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
John C. Dummer, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN C. DUMMLER, JR. | | 23D. ADDRESS
UNIVERSITY OF MD. HOSPITAL BALTIMORE, MD. 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-15-1965 | | 24C. NAME OF CEMETERY or CREMATORY
Fairfield Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
West Lafayette, Ohio | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Jackson | | 25C. FUNERAL DIRECTOR
Singleton Funeral Home / Glen Burris, Md. | |

V

V

Handwritten notes and markings, including a large 'V' and various illegible characters.

BALTIMORE CITY HEALTH DEPARTMENT

65 7333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7333

BIRTH NO. _____ M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **HERMAN D. FLOYD** 2. DATE AND HOUR PRONOUNCED DEAD **July 11, 1965 5:40 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **44 Union Memorial Hospital** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **44 Union Memorial Hospital** 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

6. STREET ADDRESS (If rural, give location) **538 Winston Avenue**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) _____ 8. DATE OF BIRTH **Jan. 6, 1929** 9. AGE (In years last birthday) **36** 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10B. KIND OF BUSINESS OR INDUSTRY **Steel Mill** 11. BIRTHPLACE (State or foreign country) **Balto. Md.** 12. CITIZEN OF WHAT COUNTRY? _____

13. FATHER'S NAME **Emanuel Floyd** 14. MOTHER'S MAIDEN NAME **Helen Munnay**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes WW II** 16. SOCIAL SECURITY NO. _____ 17. INFORMANT **Cleo Stewart** ADDRESS **3020 Hartford Rd.**

18. CAUSE OF DEATH **Stab Wound of Chest.** INTERVAL BETWEEN ONSET AND DEATH _____

(A) DUE TO _____

(B) DUE TO _____

(C) _____

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☒ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) **Home** 21C. WHERE DID INJURY OCCUR? **538 Winston Avenue**

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **7 11 '65 A** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Stabbed during altercation.**

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **7/11/65**

EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **July 15, 1965** 23C. NAME OF CEMETERY or CREMATORY **Balto. National Cem** 23D. LOCATION (City, town, or county) (State) **Balto. Md.**

24A. DATE REC'D BY HEALTH DEPT. **JUL 14 1965** 24B. NAME OF REGISTRAR **Robert E. Fairbank** 24C. FUNERAL DIRECTOR **Williams Funeral Home** ADDRESS **319 N. Schroeder St**

James M. Smith
John M. Smith
John M. Smith
John M. Smith

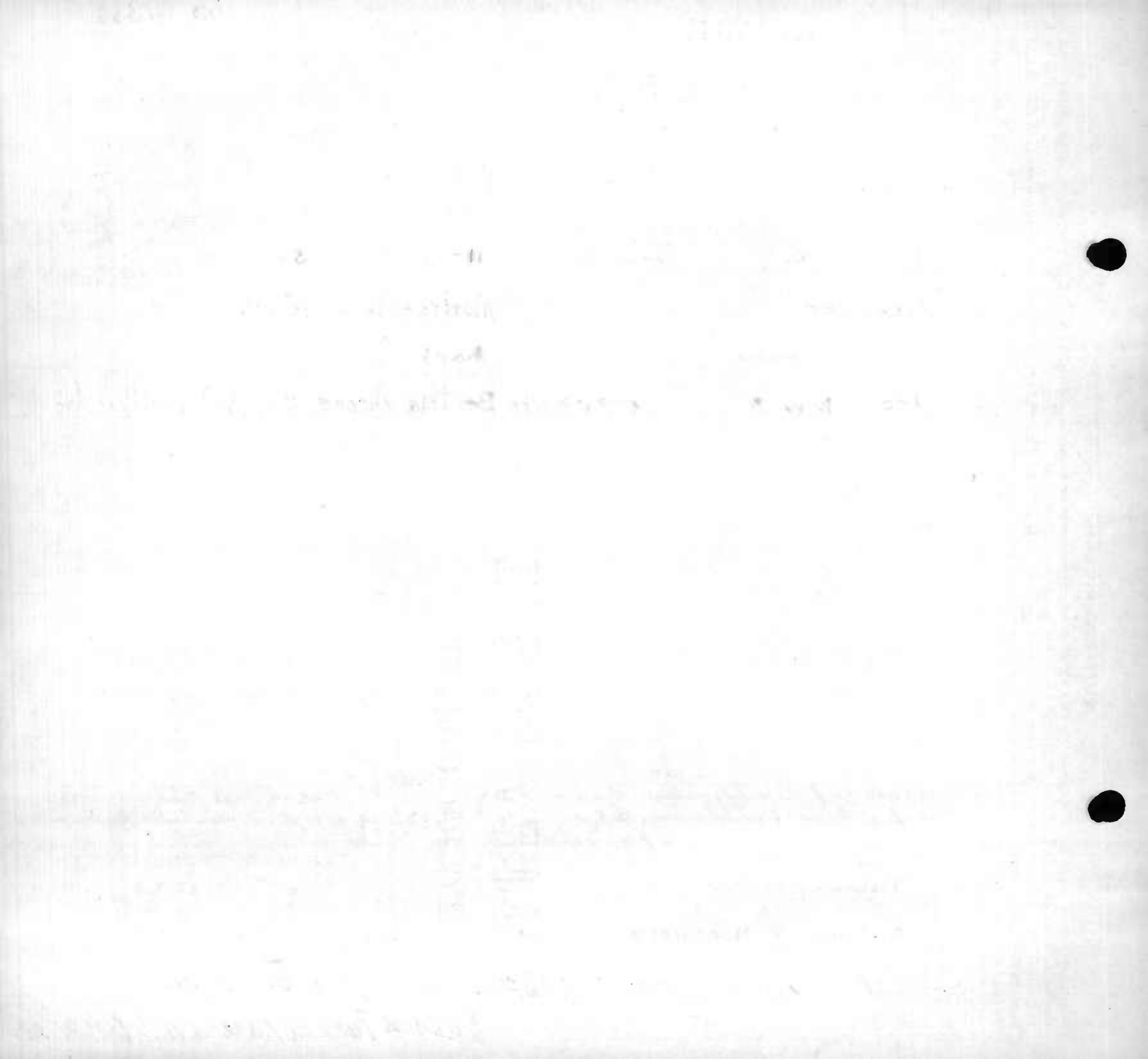
John M. Smith
John M. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------------|--|--|--|---|
| BIRTH NO. 65 7334 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7334 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Moore Charles F.</u> | | | 12 July 65 2:25 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>38 University Hospital</u> | | | A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<u>434 N. Carrollton Ave</u> | | |
| 5. SEX
<u>M</u> | 6. RACE
<u>C</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<u>married</u> | 8. DATE OF BIRTH
<u>11-25-10</u> | 9. AGE (In years last birthday)
<u>54</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<u>Murfreesboro TENN.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> |
| 13. FATHER'S NAME
<u>Wm. F. Moore</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Mary ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>679-093185</u> | 17. INFORMANT
<u>Bertha Moore</u> | | |
| | | | ADDRESS
<u>434 N. Carrollton Ave</u> | | |
| 18. <u>792X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) <u>Uremia</u>
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>?</u> |
| | | | (B) _____
DUE TO | | |
| | | | (C) _____
DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11 July</u> 19 <u>65</u> to <u>12 July</u> 19 <u>65</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12 July</u> 19 <u>65</u> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>Richard P. Norgaard</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>12 July 65</u> |
| 23C. PHYSICIAN'S NAME (Type)
<u>RICHARD P. NORGAARD</u> | | | 23D. ADDRESS
<u>University Hospital</u> | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | 24B. DATE
<u>July 14, 1965</u> | 24C. NAME OF CEMETERY or CREMATORY
<u>Balto. National Cem.</u> | | 24D. LOCATION (City, town or county) (State)
<u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 14 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farkley, M.D.</u> | | 25C. FUNERAL DIRECTOR
<u>Williams Funeral Home</u> | |
| | | | | ADDRESS
<u>N. Schorck St.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

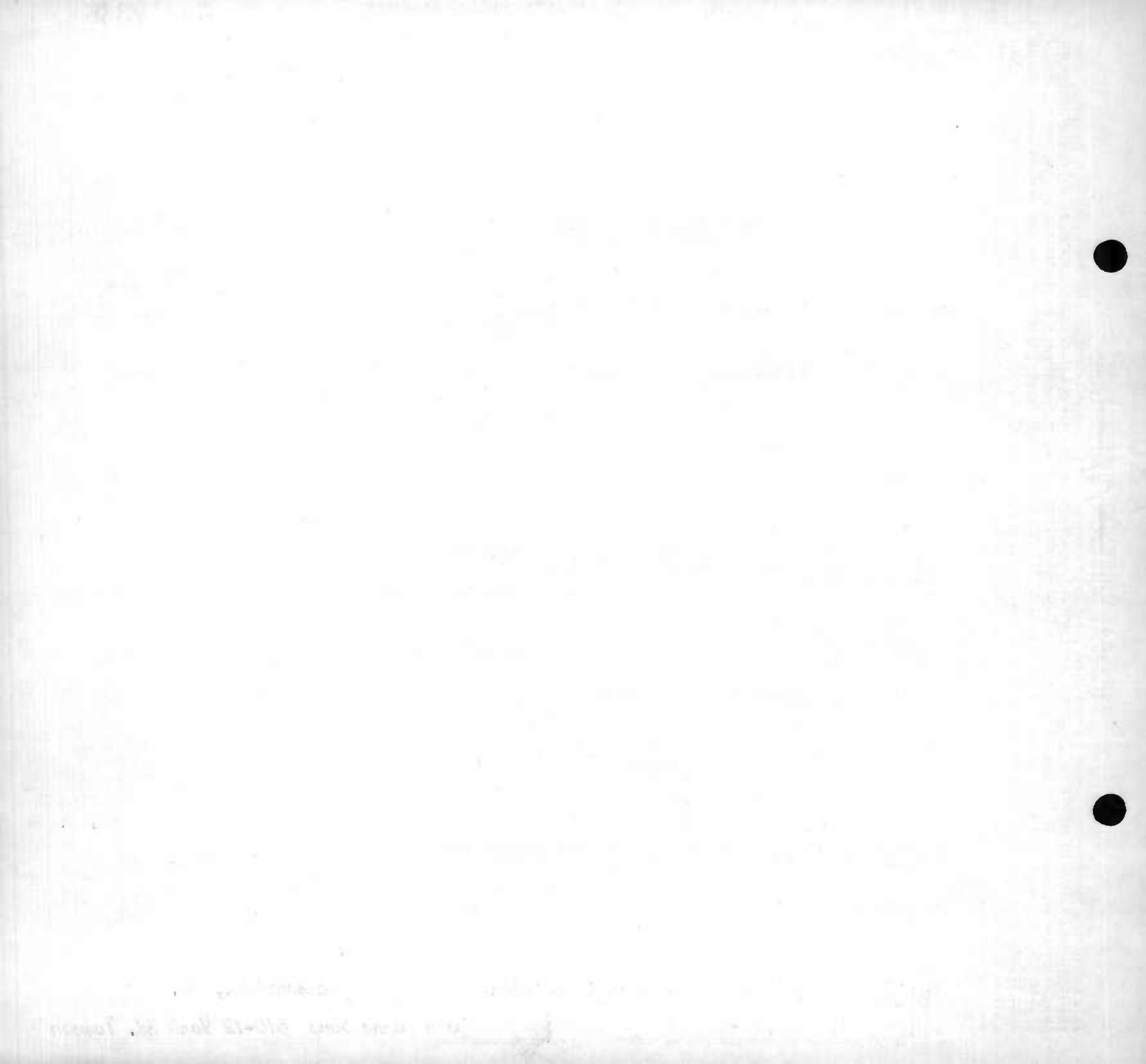
| BIRTH NO. 65-2335 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 7335 | |
|---|---------------|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) JACKSON, RUTH BERTHA | | 2. DATE AND HOUR OF DEATH 7/9/65 3:17 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY Balto | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300 | |
| 14 Union Memorial Hospital | | | | D. STREET ADDRESS (If rural, give location) 8721 Loch bend Drive | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 8/24/09 | 9. AGE (In years lost birthday) 55 54 Yr | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? American | |
| 13. FATHER'S NAME Robert Altland | | | | 14. MOTHER'S MAIDEN NAME Bertha Baer | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Dr. K. M. Anandiah | | ADDRESS 33rd Calvert, U.M.H. | |
| 18. 581.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH Hepatic Coma | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Laennec's Cirrhosis | | | | | |
| | | | | (B) DUE TO | | | | | |
| | | | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/19/65 to 7/9/65, that (I) (we) last saw the deceased alive on 7/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE K. M. Anandiah | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/9/65 | |
| 23C. PHYSICIAN'S NAME (Type) K. M. ANANDIAH | | | | | | 23D. ADDRESS Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/12/65 | | 24C. NAME OF CEMETERY or CREMATORY Mays Chapel Cemetery | | 24D. LOCATION (City, town, or county) Timonium Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 14 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John Burns Son's | | ADDRESS Towson 4, Md. | | | |

100-100000

100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|---|------------------------------|--|---|
| BIRTH NO. 65 7337 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7337 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) CLARK, FRANCIS HARRY | | 2. DATE AND HOUR OF DEATH
7/12/65 | | 9:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 UNIVERSITY HOSPITAL | | A. STATE MARYLAND
B. COUNTY AD
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
XXXXXXXXXXXXXXX
D. STREET ADDRESS (If rural, give location)
93 Mary Lane Apt #101 | | | |
| 5. SEX
m | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
5-13/130 | 9. AGE (In years last birthday)
35 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BRAKEMAN | | 10B. KIND OF BUSINESS OR INDUSTRY
B&O R.R. | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
HARRY F. CLARK | | 14. MOTHER'S MAIDEN NAME
Mary C. Daly | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WWII | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Wife - Bernice Clark | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
193.0 I
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) Narrows of cerebellum + spinal cord
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
9 months | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5-7-1965 to 7-12-1965, that (I) (we) last saw the deceased alive on 7-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ravindran E. Vardhan M.D. | | 23B. DATE SIGNED
7-12-65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
TITAVATCHAI | | 23D. ADDRESS
University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-15-65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Finken | | 25C. FUNERAL DIRECTOR
Howard H. Hubbard-4107 Wilkens Avenue 21229 | |

to the amount of 100

has been paid

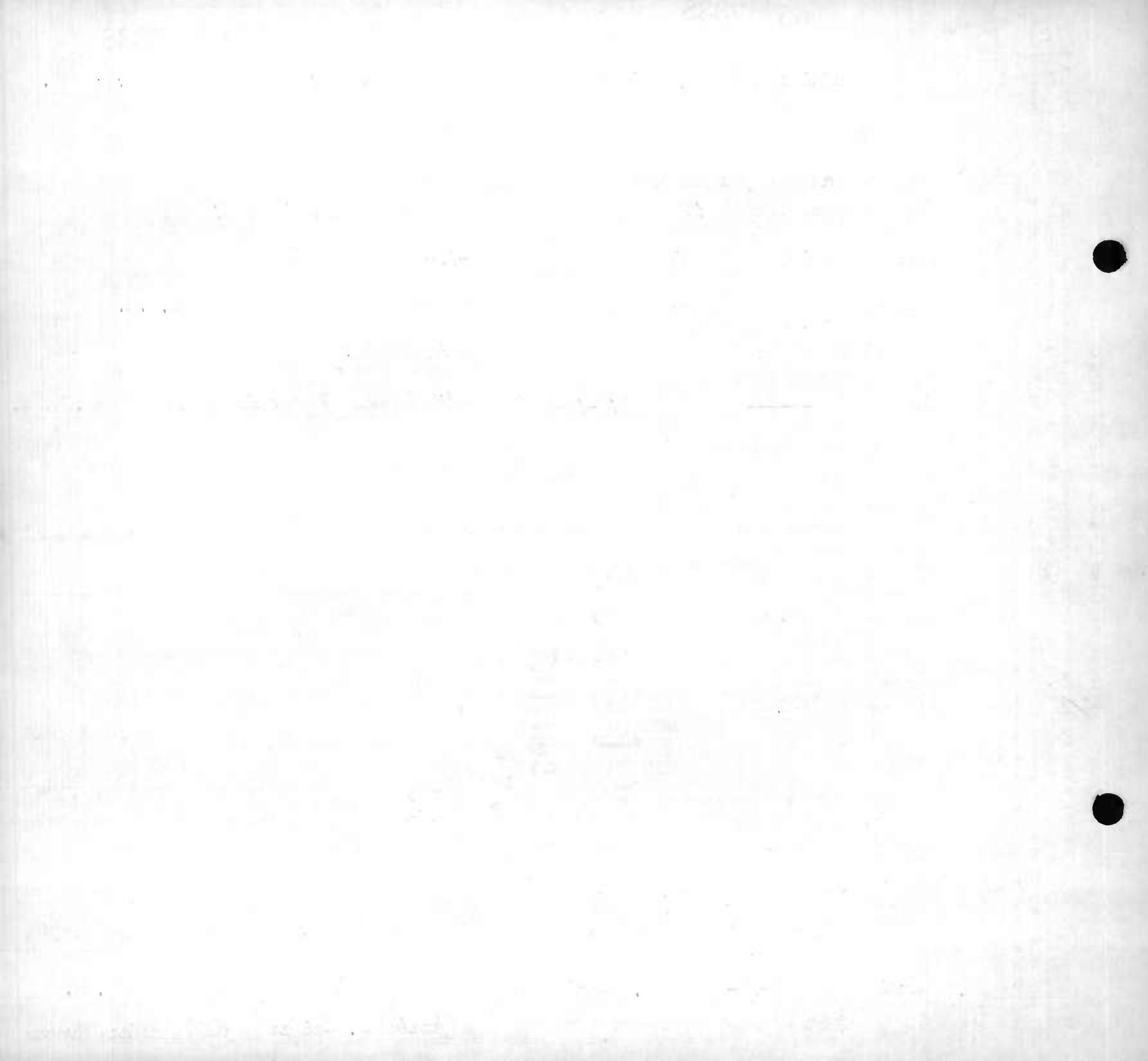
③

to the amount of 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7338 | |
|---|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. 65 7338 | | CERTIFICATE OF DEATH | | Registered No. 65 7338 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Wojciech (George) Lipka</i> | | 2. DATE AND HOUR OF DEATH
<i>July 10, 1965</i> <i>9:45 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>1-05</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>Harford Gardens Convalescent Home</i>
<i>4700 Harford Road # 14</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<i>2225 Gough Street # 31</i> | | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widowed</i> | 8. DATE OF BIRTH
<i>4-10-77</i> | 9. AGE (in years last birthday)
<i>88</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Supervisor</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Poland</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Wojciech Lipka</i> | | 14. MOTHER'S MAIDEN NAME
<i>Julianna ?</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>216-10-4954</i> | | 17. INFORMANT
<i>Julia Thomas</i> ADDRESS
<i>7400 Fair Avenue Balto. 24, Md.</i> | |
| 18. <i>491X1</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Pneumonia</i>
DUE TO
(B) <i>Generalized Arteriosclerosis</i>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 week</i>
<i>Several years</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1963</i> 19 <i>July 9</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>July 9</i> 19 <i>65</i> and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Loy M. Zimmerman</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>7/12/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Loy M. Zimmerman</i> | | 23D. ADDRESS
<i>3202 Harford Rd Baltimore Md</i> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7-14-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>St. Stanislaus Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>6515 Boston Street Balto. Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 14 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR
<i>Charles S. Zeiler</i> ADDRESS
<i>6224 Eastern Avenue</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | |
|--|--|------------------|----------------------|--|--|-----------------------------|--|--|---|--|--|-----------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 7339 | | | | | | | | |
| BIRTH NO.
65 7339 | | M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) JUNE S. MALONE (JULIA S. MALONE) | | | | | 2. DATE AND HOUR OF DEATH
July 10, 1965 12:00 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY
Maryland, Baltimore | | | | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
LUTHERVILLE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
48 MARYLAND GEN. HOSPITAL | | | | | D. STREET ADDRESS (If rural, give location)
2012 Dumont Rd. | | | | | | | | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | | 8. DATE OF BIRTH
5/28/08 | | 9. AGE (In years lost birthday)
57 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Machine Operator | | | | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Z. H. STEVENS | | | | | 14. MOTHER'S MAIDEN NAME
Lucy Williams | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | | 16. SOCIAL SECURITY NO.
217-03-3920 | | 17. INFORMANT
Virginia Little for - James | | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH
(A) DUE TO Shock
(B) DUE TO Myocardial Infarction
(C) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/20 1965 to 7/10 1965, that (I) (we) last saw the deceased alive on 7/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE
Sabundayo, Rolando | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-10-65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
ROLENDO SABUNDAYO | | | | | | | | 23D. ADDRESS
MD, GENERAL HOSP. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
7-13-65 | | 24C. NAME OF CEMETERY or CREMATORY
Dulaney Valley Memor. Gardens | | | | 24D. LOCATION (City, town, or county) (State)
200 Padonia Rd. Balto. Co. Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | | | 25B. NAME OF REGISTRAR
A. E. Johnson | | | | 25C. FUNERAL DIRECTOR ADDRESS
Charles Zeile - 901 S. Conkling St. | | | | | |

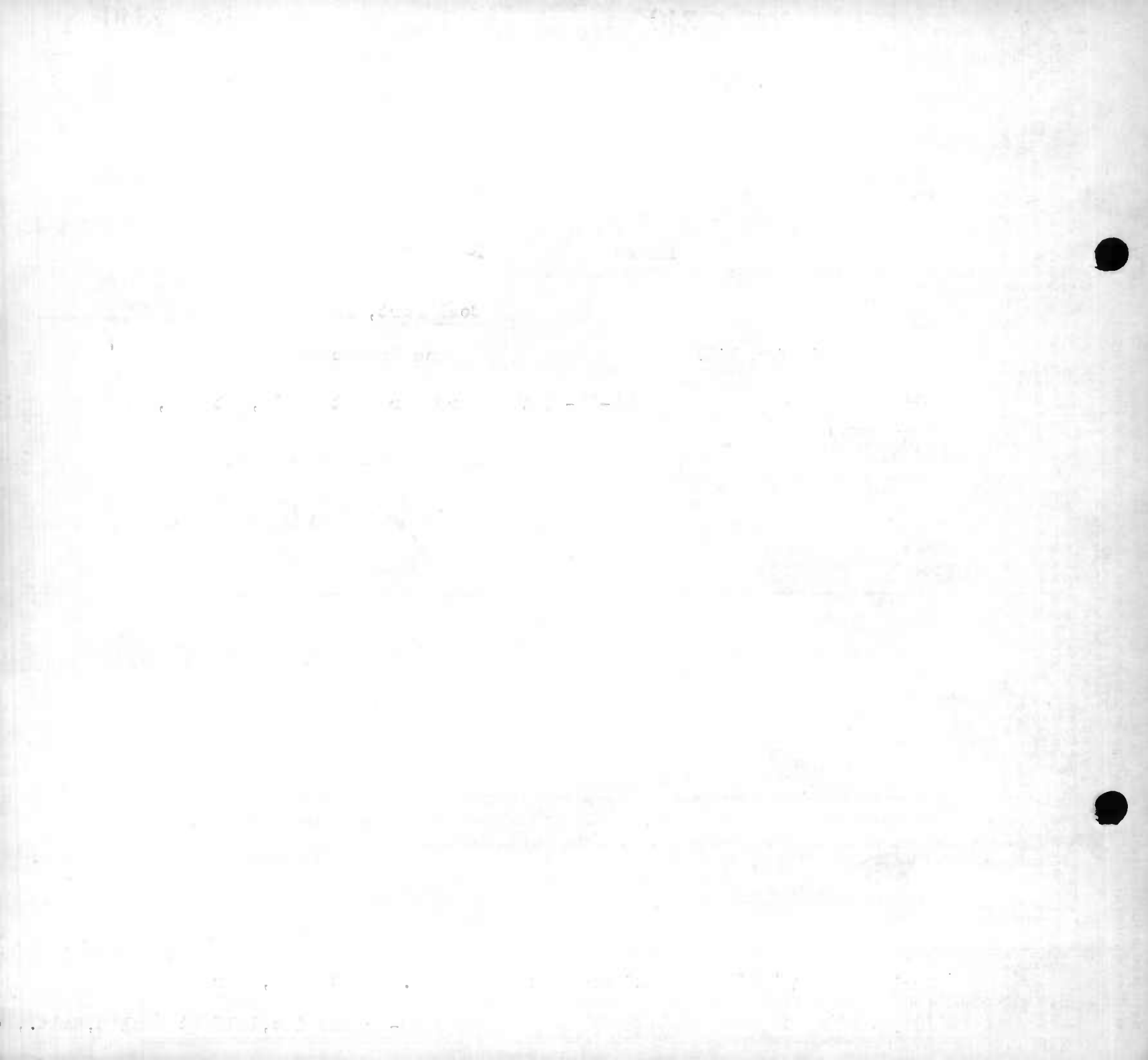
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---|---|--|---|---|
| BIRTH NO. 65 7340 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7340 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) AGNES M. GEORGE | | 2. DATE AND HOUR OF DEATH
July 10, 1965 17:35 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY 12-15 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland Gen. Hospital 48 | | D. STREET ADDRESS (If rural, give location)
9. E. Lafayette | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
7/12/01 | 9. AGE (In years lost birthday)
64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Coal Port, Pa | |
| 12. CITIZEN OF WHAT COUNTRY?
USA. | | 13. FATHER'S NAME
William Hill | | 14. MOTHER'S MAIDEN NAME
Anne Hogancamp | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
214-14-5757 | | 17. INFORMANT ADDRESS
Mrs Margaret Ellis, Altoona, Pa | |
| 18. 434.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

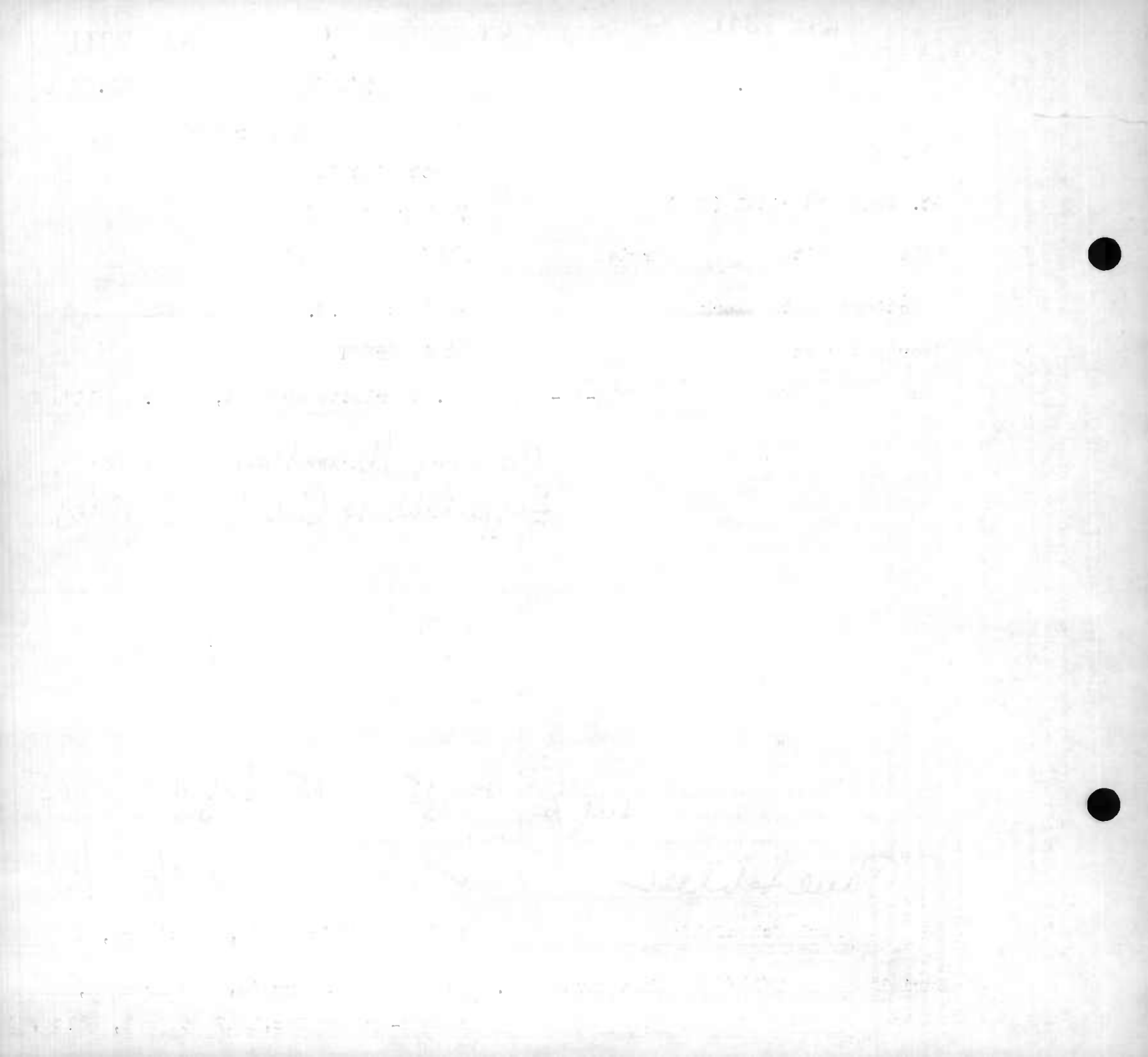
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH
(A) Pulmonary Edema
DUE TO
(B) Congest Heart failure
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 10 1965 to July 10 1965 , that (I) (we) last saw the deceased alive on July 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Holmes & Bradbury | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-10-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
Maryland Gen. Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/14/65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National Ceme. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 14 1965 | | 25B. NAME OF REGISTRAR
Robert E. Falkner | | 25C. FUNERAL DIRECTOR ADDRESS
Wm Cook-Brooks inc, 1217 St Paul St, Balt., Md | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOE

JOSEPH J. BROWN

2. DATE AND HOUR PRONOUNCED DEAD

9 July 1965

6:47 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE CORRECTED 7-26-65

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2027 Maryland Ave.

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

Jan 5, 1909

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Supply Store

11. BIRTHPLACE (State or foreign country)

Clifton Forge, Va

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Leonard Brown

14. MOTHER'S MAIDEN NAME

Iva Mealey - Nealey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL
SECURITY NO.

719-07-4750

17. INFORMANT

Record

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

7/11/65

23C. NAME of CEMETERY or CREMATORY

Allegheny Memorial Park

23D. LOCATION

(City, town, or county)

Lawnmoore, Virginia

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 14 1965

Wm Cook-Brooks, St Paul st, Balto, Md

V.S. 153

7-26-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65-7343 | |
|--|--|---------------------------------|--|------------------------------------|--|
| BIRTH NO. 65-7343 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | Registered No. 65-7343 | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Bertha Burlingham | | | 7/9/65 11:40 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| South Baltimore General Hospital | | | Maryland | | |
| 5. SEX | | | 6. RACE | | |
| Female | | | White | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | | |
| Widow | | | 12/13, 1891 | | |
| 9. AGE (In years last birthday) | | | 10. CITIZEN OF WHAT COUNTRY? | | |
| 73 | | | U.S.A. | | |
| 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Baltimore, Maryland | | | U.S.A. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| George Zick | | | Elizabeth K. Horn | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| No | | | 215-22-5942 | | |
| 17. INFORMANT | | | ADDRESS (19) | | |
| Mrs. Mildred E. Browning | | | 3104 Lynch Road | | |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CONGESTIVE HEART FAILURE | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | DUE TO | | |
| ANTECEDENT CAUSES | | | DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | DUE TO | | |
| II | | | DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | DUE TO | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 2 | | | Yes | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Yes | | | Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| No | | | No | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED | | |
| (Month) (Day) (Year) (Hour) | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| No | | | No | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/2/65 to 7/9/65, that (X) (we) last saw the deceased alive on 7/9/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Matthew Z. Kaufman, M.D. | | | 7/10/65 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| MATTHEW Z. KAUFMAN, M.D. | | | South Balto. Gen. Hosp. - 1213 Light St. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | July 13, 65 | | Meadowridge Mem. Park | |
| 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| Elkridge Howard Co. Md. | | JUL 14 1965 | | Wm. Cook-Brooks, Inc. | |
| 24G. ADDRESS | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR | |
| 1217 St. Paul St. | | Wm. Cook-Brooks, Inc. | | 1217 St. Paul St. | |



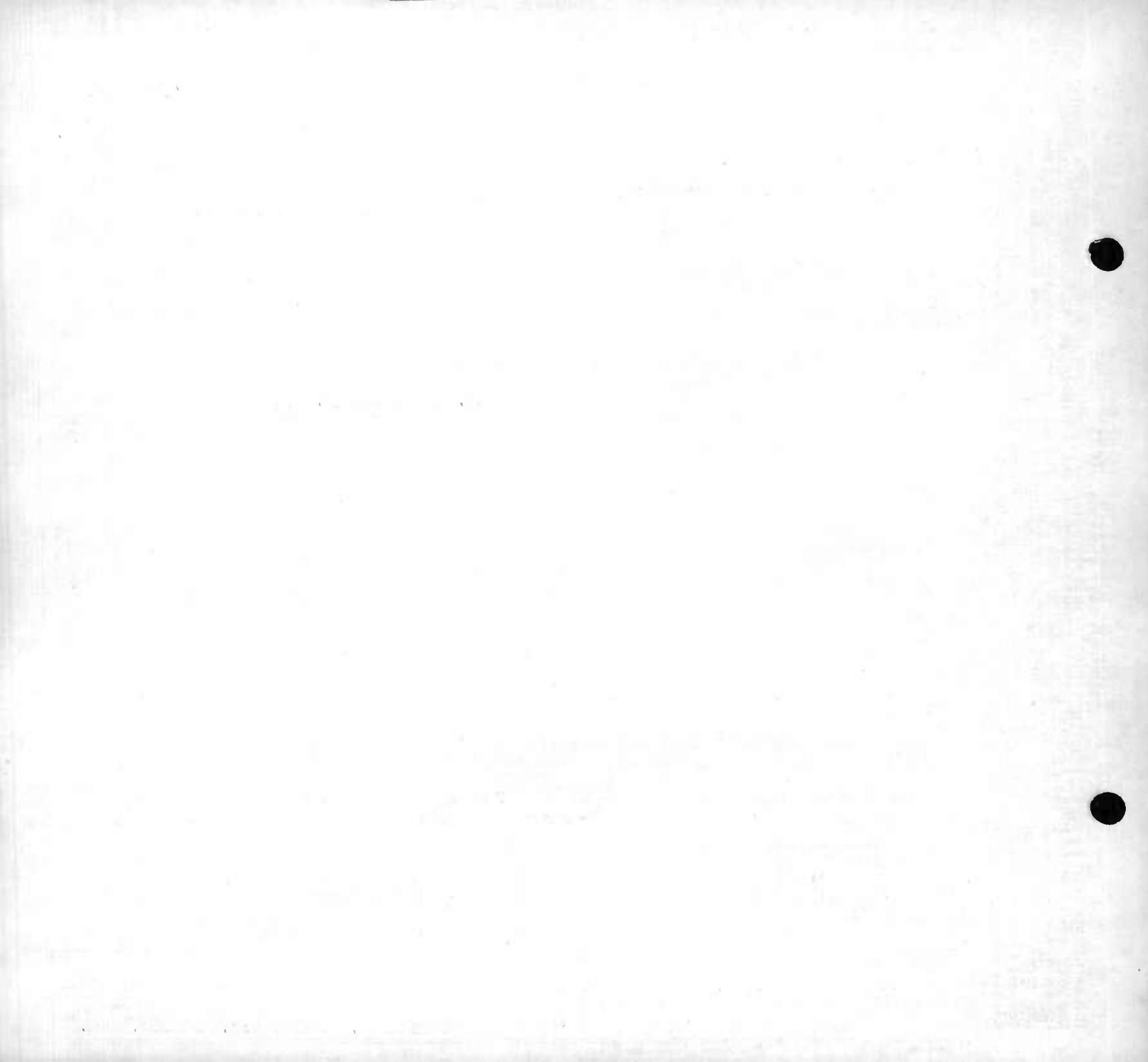
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7344 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 7344 | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH
7:05 PM July 18, 1965 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) HARNEK Mrs. Elizabeth | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 7612 Perring Terrace 5300 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bon Secours Hospital | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M 8. DATE OF BIRTH 3/13/1910 9. AGE (In years last birthday) 55 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (State or foreign country) Baltimore Md 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Carroll Parks | | 14. MOTHER'S MAIDEN NAME Bessie Cox | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. Bernard J. Harnek | | ADDRESS Same | | | |
| 18. 1533 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

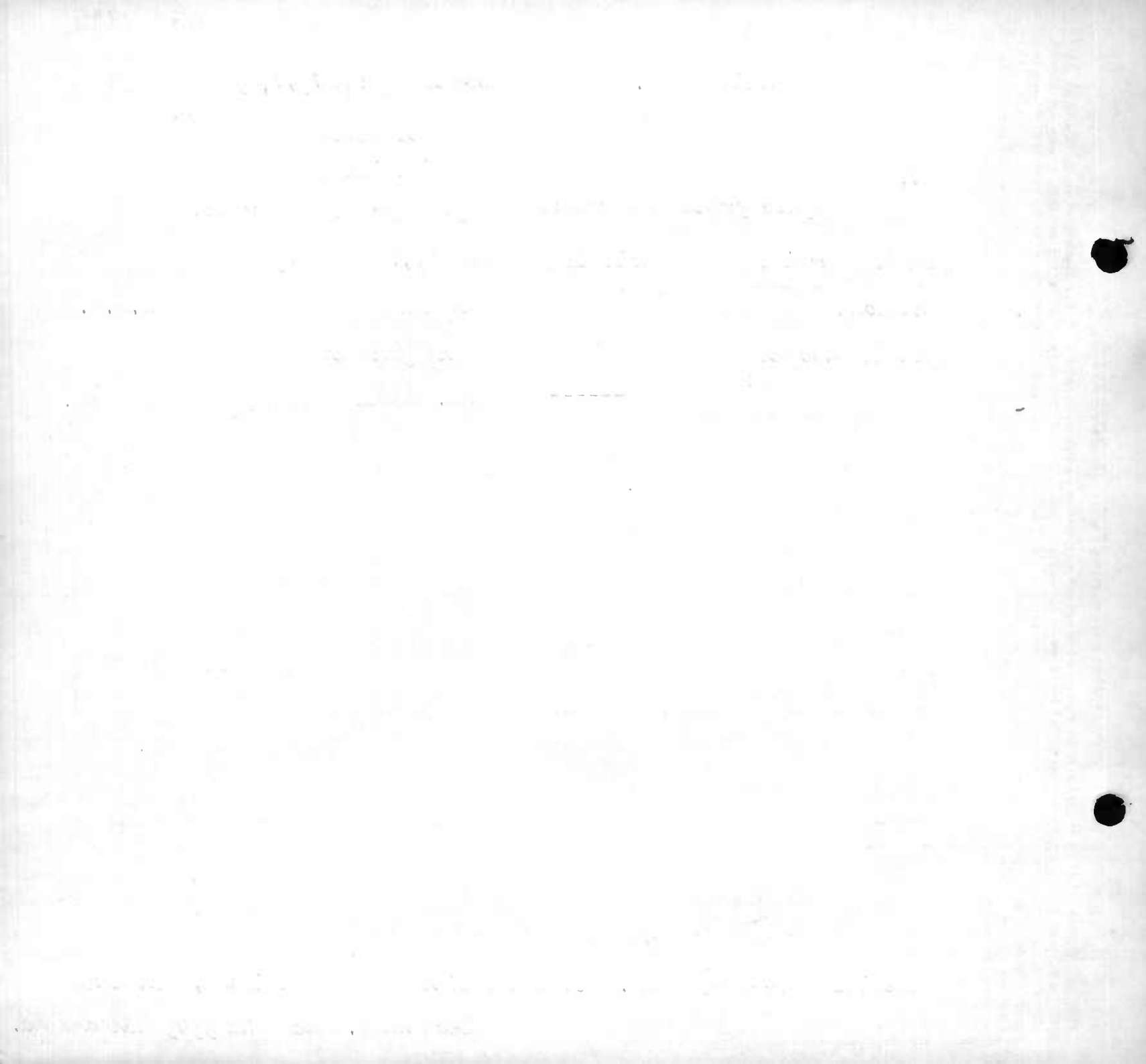
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) generalized peritonitis
DUE TO
(B) adenocarcinoma of sigmoid colon
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
hours | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 7-8-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of Sigmoid | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-2-1965 to 7-13-1965 , that (I) (we) last saw the deceased alive on 7-13-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pichit Wathanapaisarl M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/13/65 | |
| 23C. PHYSICIAN'S NAME (Type) PICHIT WATHANAPAISARL M.D. | | 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park, Baltimore, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. JUL 14 1965 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7345 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7345 | |
|---|-------------------------|--|---|---|---|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Annie E. Hooper</i> | | | | 2. DATE AND HOUR OF DEATH
<i>July 13, 1965</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>oo</i> | | | | A. STATE <i>Maryland</i>
B. COUNTY <i>2802</i> | | | |
| (If not in hospital or institution, give street address or location)
<i>5206 Gwynn Oak Avenue</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
<i>5206 Gwynn Oak Avenue</i> | | | |
| 5. SEX
<i>female</i> | 6. RACE
<i>white</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>single</i> | 8. DATE OF BIRTH
<i>May 27, 1880</i> | 9. AGE (In years lost birthday)
<i>85</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>at home</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> |
| 13. FATHER'S NAME
<i>Charles Hooper</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Younger</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
----- | | 17. INFORMANT ADDRESS
<i>Mrs. Belle Denton 7010 Arion Ave.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>332X I</i>
CAUSE OF DEATH
<i>Thrombosis Cerebral</i>
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>acute</i> | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>65</i> to <i>July 13</i> 19 <i>65</i> , that (I) was last saw the deceased alive on <i>July 13</i> 19 <i>65</i> and that in (my) an opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>E J Mendels</i> M.D. | | | | 23B. DATE SIGNED
<i>7/13/65</i> | | 23C. PHYSICIAN'S NAME (Type)
<i>E J Mendels</i> M.D. | |
| 23D. ADDRESS
<i>2308 Edmondson Bldg 23 Md</i> | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7/15/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Mt. Olivet Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 14 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fairbank</i> | | 25C. FUNERAL DIRECTOR ADDRESS
<i>Leonard J. Rulek Inc 5305 Harford Rd.</i> | | | |



BALTIMORE CITY HEALTH DEPARTMENT

65 7346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7346

B-260

1

BIRTH NO. M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOSEPH J. ~~BAKER~~ Becker

2. DATE AND HOUR PRONOUNCED DEAD July 13, 1965 5:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-06

D. STREET ADDRESS (If rural, give location) 1504 E. Oliver Street

5. SEX Male

6. RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed

8. DATE OF BIRTH Dec. 18, 1880

9. AGE (In years, lost birthday) 84

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Employee Baltimore G & E Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Becker

14. MOTHER'S MAIDEN NAME Maria Bauer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 212054698

17. INFORMANT ADDRESS Joseph F. Becker 3820 E. Pratt Street

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 7/14/65

23A. BURIAL CREMATION, REMOVAL (Specify) burial

23B. DATE 7-17-65

23C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.

23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. JUL 14 1965

24B. NAME OF REGISTRAR Robert E. Taylor

24C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md.

WALLLEY
PRICE

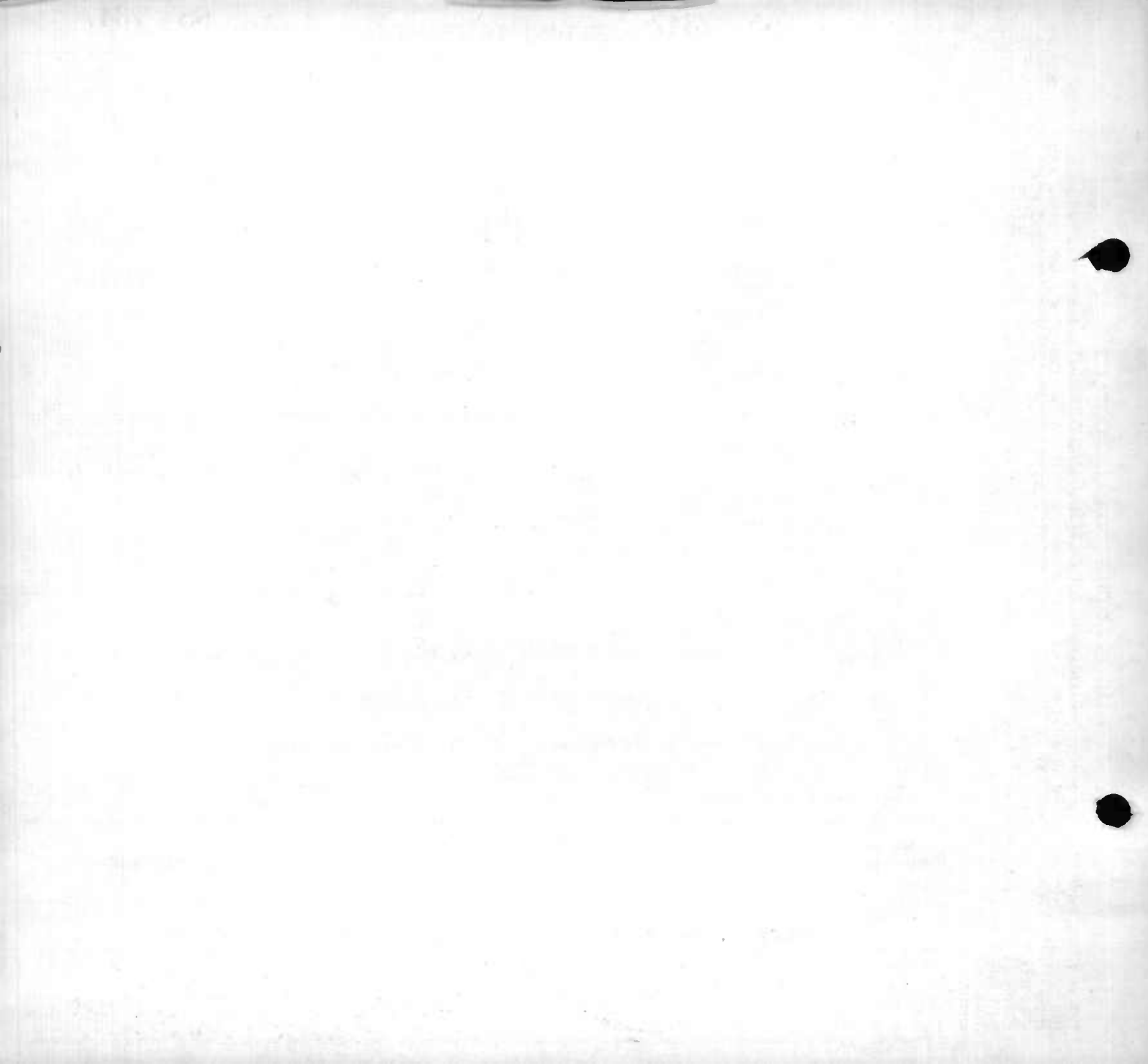
NO. 1000000000

Class 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|---|---------------------------|---|--|
| BIRTH NO. 65 7347 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7347 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) William Sylvester Edwards | | 2. DATE AND HOUR OF DEATH 7/13/65 2:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-11 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Md. Hospital | | D. STREET ADDRESS (If rural, give location) 3405 Calhoun Ave | | 2/215 | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-16-87 | 9. AGE (in years, lost birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer - Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Archer's Laundry | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John S Edwards | | 14. MOTHER'S MAIDEN NAME Louisa Hanson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unt | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Henry A. Saiontz MD ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Bacterial Pneumonitis DUE TO (B) Multiple Myeloma DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 36 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-24-1965 to 7-13-1965, that (I) (we) last saw the deceased alive on 7-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry A. Saiontz | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type) Henry A. Saiontz | | M.D. UNIVERSITY HOSP. | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Bkfst. Trd. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | 25E. FUNERAL HOME | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

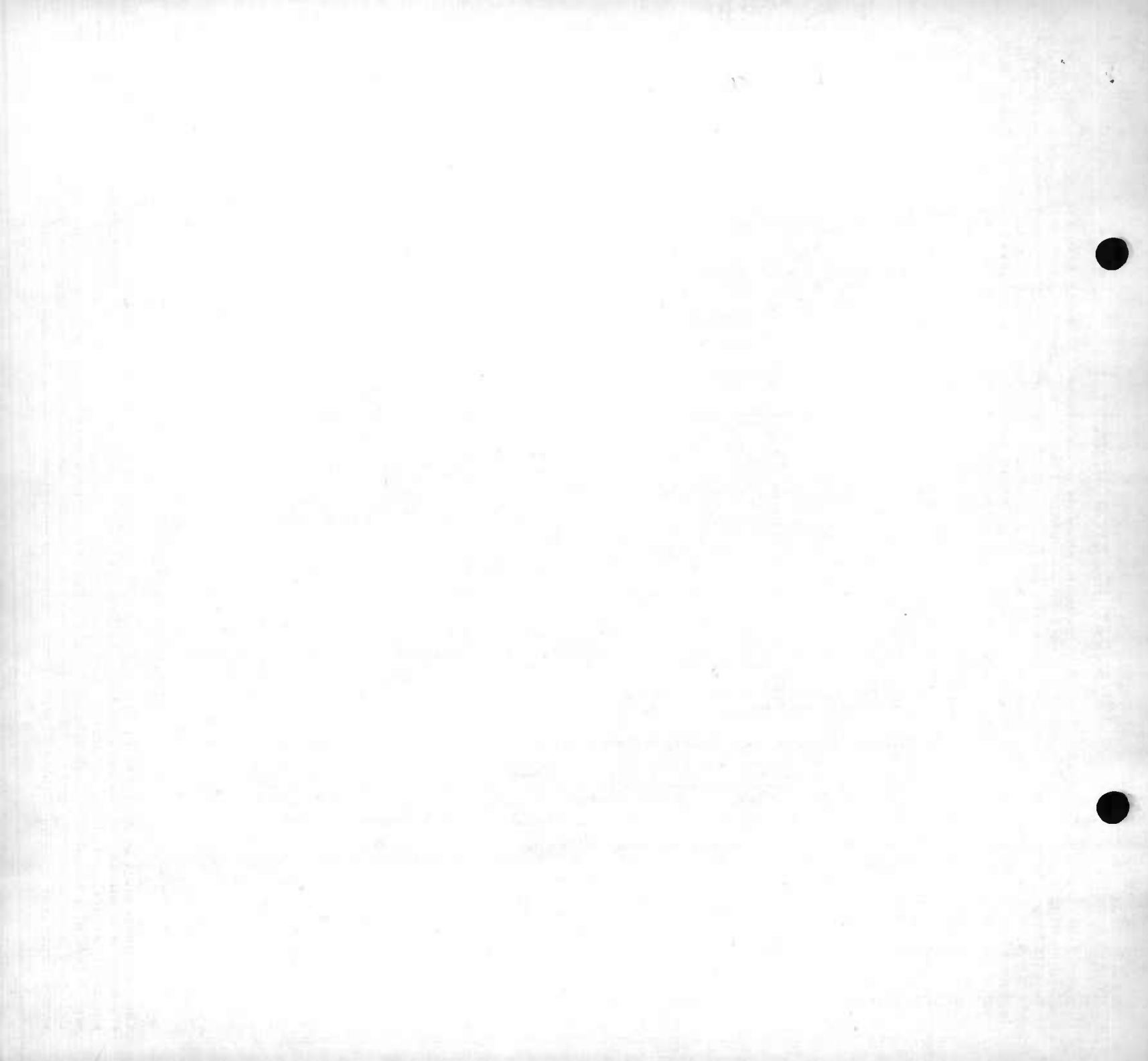
| | | | | | |
|---|--|---|--|--|--|
| BIRTH NO. 65-7348 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65-7348 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) WYATT MADDEN | | 2. DATE AND HOUR OF DEATH
11 July, 1965 7:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. AGE (In years lost birthday) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
SINAI HOSPITAL | | A. STATE MARYLAND
B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Reisterstown 33-00 | |
| D. STREET ADDRESS (If rural, give location)
42 BOND AVENUE | | 6. RACE
NEGRO | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
NEVER MARRIED | |
| 8. SEX
MALE | | 9. DATE OF BIRTH
11-6-12 | | 10. AGE (In years lost birthday)
52 | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Asbury A. Madden | |
| 14. MOTHER'S MAIDEN NAME
Evelyn Norris | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
217-09-4476 | |
| 17. INFORMANT
Mrs. Annie Madden | | ADDRESS
42 Bond Ave., Reisterstown, Md. | | 18. CAUSE OF DEATH | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
(B) AORTIC ANEURYSM | | 20. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
(A) CEREBRO VASCULAR ACCIDENT (pt. a)
(C) CONGESTIVE HEART FAILURE | | 21. INTERVAL BETWEEN ONSET AND DEATH
5 days | |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
DIABETES, CONGESTIVE HEART FAILURE, SICKLE CELL ANEMIA | | 23. MEDICAL CERTIFICATION | | 24. MEDICAL CERTIFICATION | |
| 25. DATE OF OPERATION
JULY 6, '65 | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 27. AUTOPSY? (Yes or No)
NO | |
| 28. DATE OF OPERATION
JULY 6, '65 | | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 31. DATE OF OPERATION
JULY 6, '65 | | 32. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 34. DATE OF OPERATION
JULY 6, '65 | | 35. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 36. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 37. DATE OF OPERATION
JULY 6, '65 | | 38. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 39. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 40. DATE OF OPERATION
JULY 6, '65 | | 41. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 42. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 43. DATE OF OPERATION
JULY 6, '65 | | 44. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 45. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 46. DATE OF OPERATION
JULY 6, '65 | | 47. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 48. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 49. DATE OF OPERATION
JULY 6, '65 | | 50. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 51. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 52. DATE OF OPERATION
JULY 6, '65 | | 53. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 54. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 55. DATE OF OPERATION
JULY 6, '65 | | 56. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 57. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 58. DATE OF OPERATION
JULY 6, '65 | | 59. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 60. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 61. DATE OF OPERATION
JULY 6, '65 | | 62. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 63. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 64. DATE OF OPERATION
JULY 6, '65 | | 65. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 66. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 67. DATE OF OPERATION
JULY 6, '65 | | 68. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 69. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 70. DATE OF OPERATION
JULY 6, '65 | | 71. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 72. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 73. DATE OF OPERATION
JULY 6, '65 | | 74. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 75. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 76. DATE OF OPERATION
JULY 6, '65 | | 77. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 78. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 79. DATE OF OPERATION
JULY 6, '65 | | 80. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 81. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 82. DATE OF OPERATION
JULY 6, '65 | | 83. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 84. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 85. DATE OF OPERATION
JULY 6, '65 | | 86. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 87. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 88. DATE OF OPERATION
JULY 6, '65 | | 89. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 90. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 91. DATE OF OPERATION
JULY 6, '65 | | 92. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 93. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 94. DATE OF OPERATION
JULY 6, '65 | | 95. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 96. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 97. DATE OF OPERATION
JULY 6, '65 | | 98. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 99. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 100. DATE OF OPERATION
JULY 6, '65 | | 101. CONDITION FOR WHICH OPERATION WAS PERFORMED
Aortic Aneurysm Repair | | 102. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 7349 | |
|--|----------------------|--|---------------------------------|--|--|
| BIRTH NO. 65 7349 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Drawn Philip</u> | | 2. DATE AND HOUR OF DEATH <u>7/13/65</u> <u>9:50 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>31 Mercy Hospital.</u> | | A. STATE <u>md.</u> B. COUNTY <u>13-01</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balta.</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>901 Lake Drive</u> <u>APT 36</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married.</u> | 8. DATE OF BIRTH <u>1/18/96</u> | 9. AGE (In years last birthday) <u>69</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Liquor</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balta, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Jacob Drawn</u> | | 14. MOTHER'S MAIDEN NAME <u>Jennie ??</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>MRS LEE DRAUN 901 LAKE DRIVE APT 36</u> | |
| 18. <u>053.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) <u>Overwhelming septicemia</u> DUE TO | | <u>12 hrs.</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>site undetermined.</u> DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>ASCVD & acute pulm. edema.</u> | | <u>24 hrs.</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> <u>1965</u> to <u>7/13</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <u>E. Lee Robbins</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>7/13/65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>E. Lee Robbins</u> | | 23D. ADDRESS <u>Mercy Hosp.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>7/14/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Mikro Kodesh - Beth Israel</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 15 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | |
| 25C. FUNERAL DIRECTOR ADDRESS <u>Pol Levinson + Bros Inc. 6010 REESTERTOWN Rd.</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

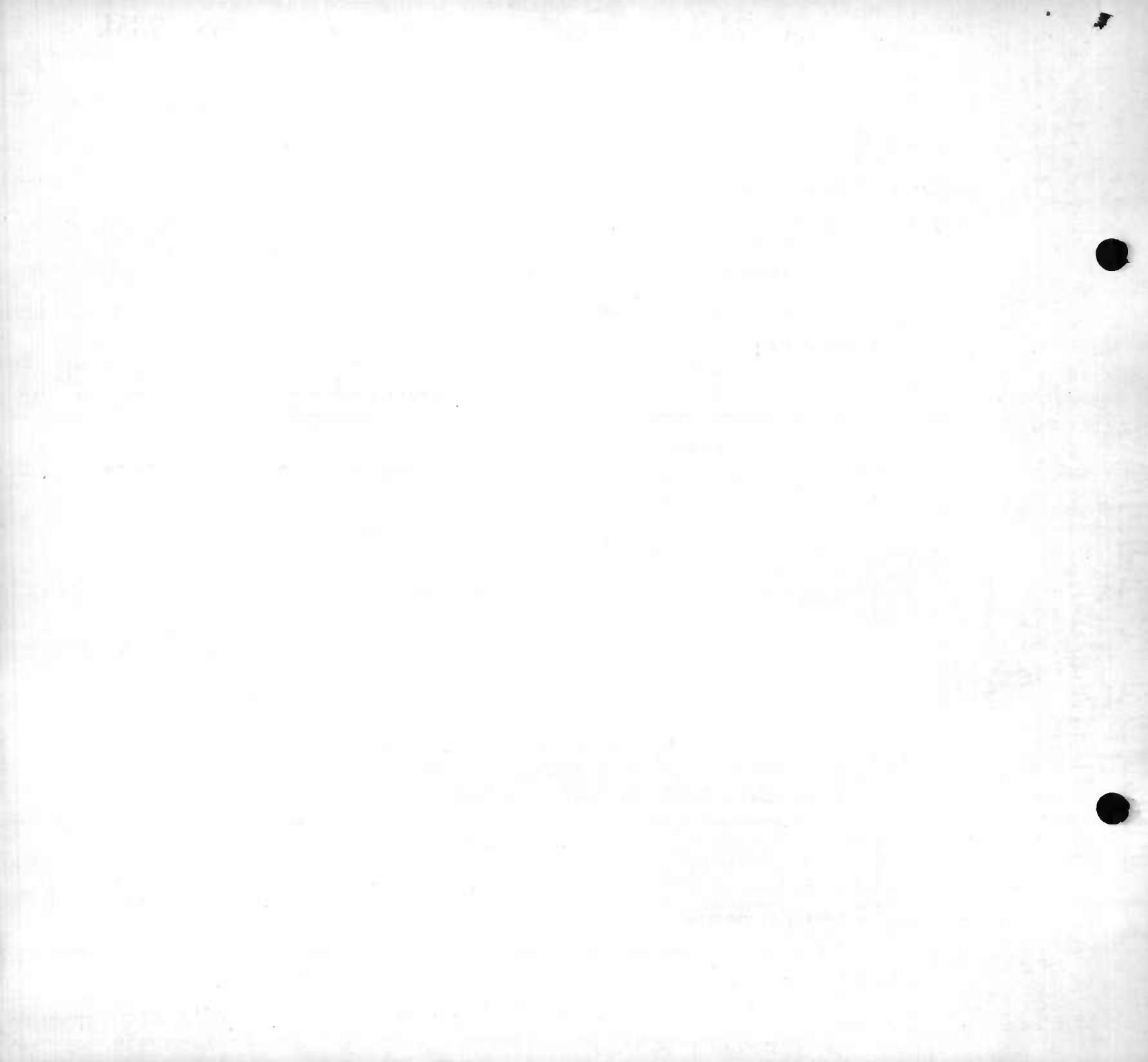
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7350 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7350 | |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. 65 7350 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) IDA MILLER | | | | 2. DATE AND HOUR OF DEATH JULY 14, 1965 6:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5502 GIST AVENUE | | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| 5. SEX FEMALE | | | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | |
| 8. DATE OF BIRTH | | | | 9. AGE (In years last birthday) 70 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME BENJAMIN BECKER | | | |
| 14. MOTHER'S MAIDEN NAME YETTA ? | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS MR. DAVID H. COHEN 110 E LEXINGTON ST | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | C. V. A. | | | |
| ANTECEDENT CAUSES | | | | H A S H D | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10 to 7/14 1965, that (I) (we) last saw the deceased alive on 7/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE DR. ISRAEL ZINBERG | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. ISRAEL ZINBERG | | | | 23D. ADDRESS 4000 NORTHERN PARKWAY | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 7/15/65 | | 24C. NAME of CEMETERY or CREMATORY BNAI ISRAEL | |
| 24D. LOCATION (City, town, or county) BALTIMORE (State) MARYLAND | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farkas, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7351 | |
|---|-------------------------|---|-----------------------------------|--|---|
| BIRTH NO.
65 7351 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Gordon, Katherine | | 2. DATE AND HOUR OF DEATH
12 July 1965 4:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital | | A. STATE Md.
B. COUNTY Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
53-00 3683 Forest Hill Rd #7 | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
8/6/86 | 9. AGE (In years last birthday)
78 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
Russia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JACOB KRIVEL | | 14. MOTHER'S MAIDEN NAME
ROSE ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NO | | 17. INFORMANT ADDRESS
MRS. VIOLA KONDRITZER 3683 FOREST HILL ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
42011 I
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Myocardial infarction | | CAUSE OF DEATH
(A) DUE TO
Arteriosclerotic Cardiovascular Disease
(B) DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
18 hr. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/2/65 19 65 to 7/12 19 65 , that (I) (we) last saw the deceased alive on 7/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Solomon Robbin | | | | 23B. DATE SIGNED
7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type) SOLOMON ROBBIN | | | | 23D. ADDRESS
Sinai Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7/14/65 | | 24C. NAME of CEMETERY or CREMATORY
BALTIMORE HEBREW | |
| 24D. LOCATION (City, town, or county) (State)
REISTERSTOWN, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |



| | | | | | |
|---|------------------|---|--------------------------------|--|---|
| 65 7352 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 7352 | |
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | MICHAEL OSHER | | 2. DATE AND HOUR PRONOUNCED DEAD
7/12/65 7:00 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore | | C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)
Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION
42 Sinai Hospital | | D. STREET ADDRESS (If rural, give location)
3403 Terrapin Rd. | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
MARRIED | 8. DATE OF BIRTH
12/25/1920 | 9. AGE (In years last birthday)
44 | If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PROPRIETOR | | 10B. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE | | 11. BIRTHPLACE (State or foreign country)
NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
JACK OSHER | | 14. MOTHER'S MAIDEN NAME
MOLLIE CHAIFETZ | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
YES WW 11 | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
NORMAN L. JEFFER COMMUNITY CHAPELS NEW YORK | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 7/13/65 | |
| 23A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 23B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 23C. NAME OF CEMETERY or CREMATORY
NEW MONTIFIORE | |
| 23D. LOCATION (City, town, or county)
PINELAWN, NEW YORK | | 23E. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | 23F. ADDRESS
6010 REISTERSTOWN RD | |

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50

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WALLACE BORDEN

JACK COOPER
W. H.
REAL ESTATE
PROPERTY
11155120
14

WOLFE CHARTER
MORRIS L. JETER COMPANY CHARTER
11155120
14

11155120
14

11155120
14

FUNERAL DIRECTOR: IMPORTANT

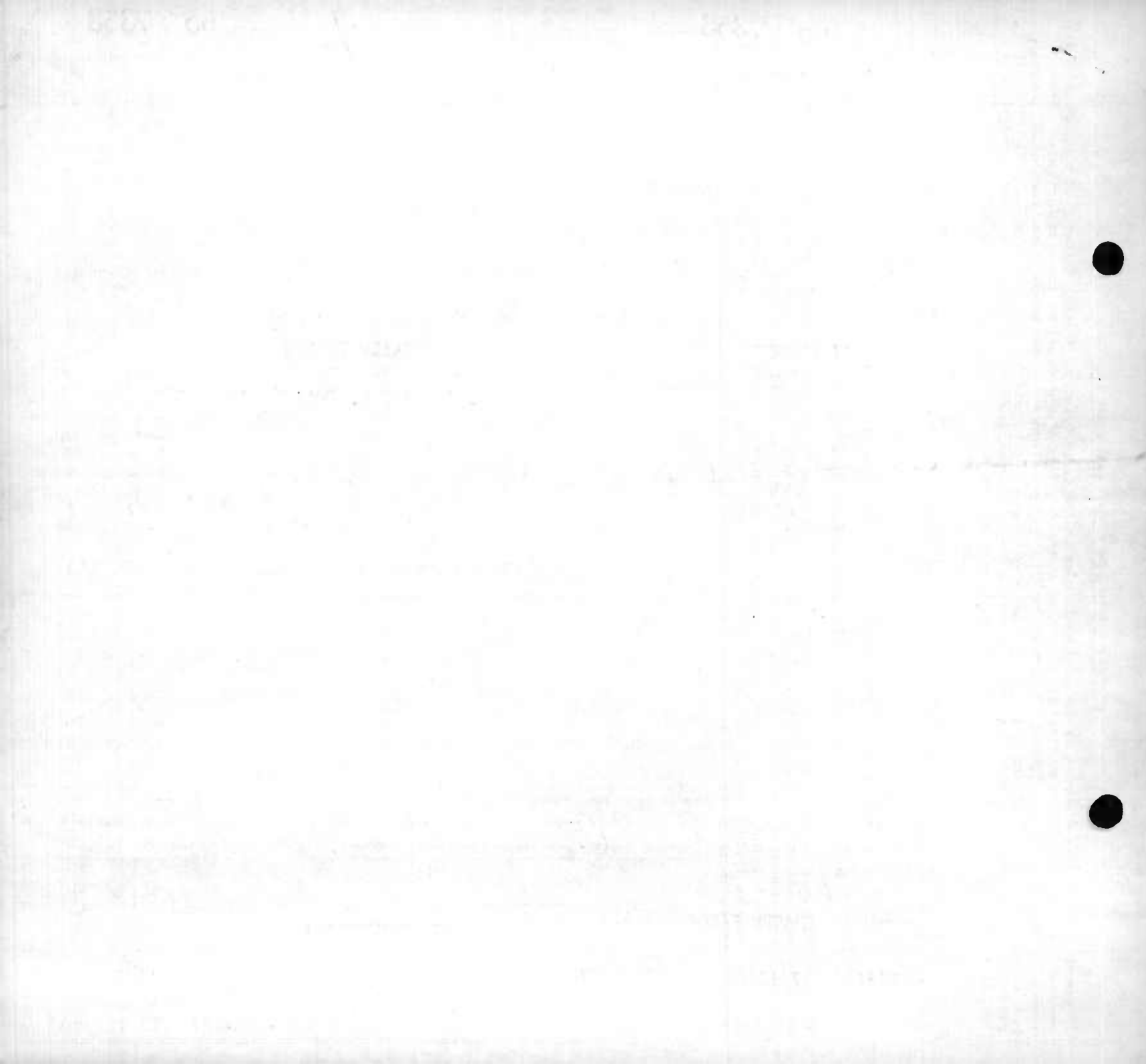
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|---|--|--|--|
| BIRTH NO. 65 7353 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7353 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Lois A. Foland | | 2. DATE AND HOUR OF DEATH
9:45 AM 7/12/65 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Sinai Hospital of Balto., Inc | | A. STATE Md.
B. COUNTY Balto | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Rural - Baltimore county | | | |
| 42 | | D. STREET ADDRESS (If rural, give location)
8548 Stevenswood Road | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
11/4/38 | 9. AGE (In years lost birthday)
26 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, BALTIMORE | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
ELI FEDDER | | 14. MOTHER'S MAIDEN NAME
SHIRLEY TRAGER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. LEONARD E. FOLAND | |
| | | | | ADDRESS
8548 STEVENSWOOD ROAD | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, | | CAUSE OF DEATH
(A) Uremia
DUE TO
(B) Diabetic glomerulosclerosis
DUE TO
(C) Diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH
?

?

15 yrs. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
None | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/21 19 65 to 7/12 19 65 , that (I) (we) last saw the deceased alive on 7/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harry Tabor | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY TABOR | | 23D. ADDRESS
SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7/13/65 | | 24C. NAME OF CEMETERY or CREMATORY
BETH TFILOH | |
| | | | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |



FUNERAL DIRECTOR: IMPORTANT

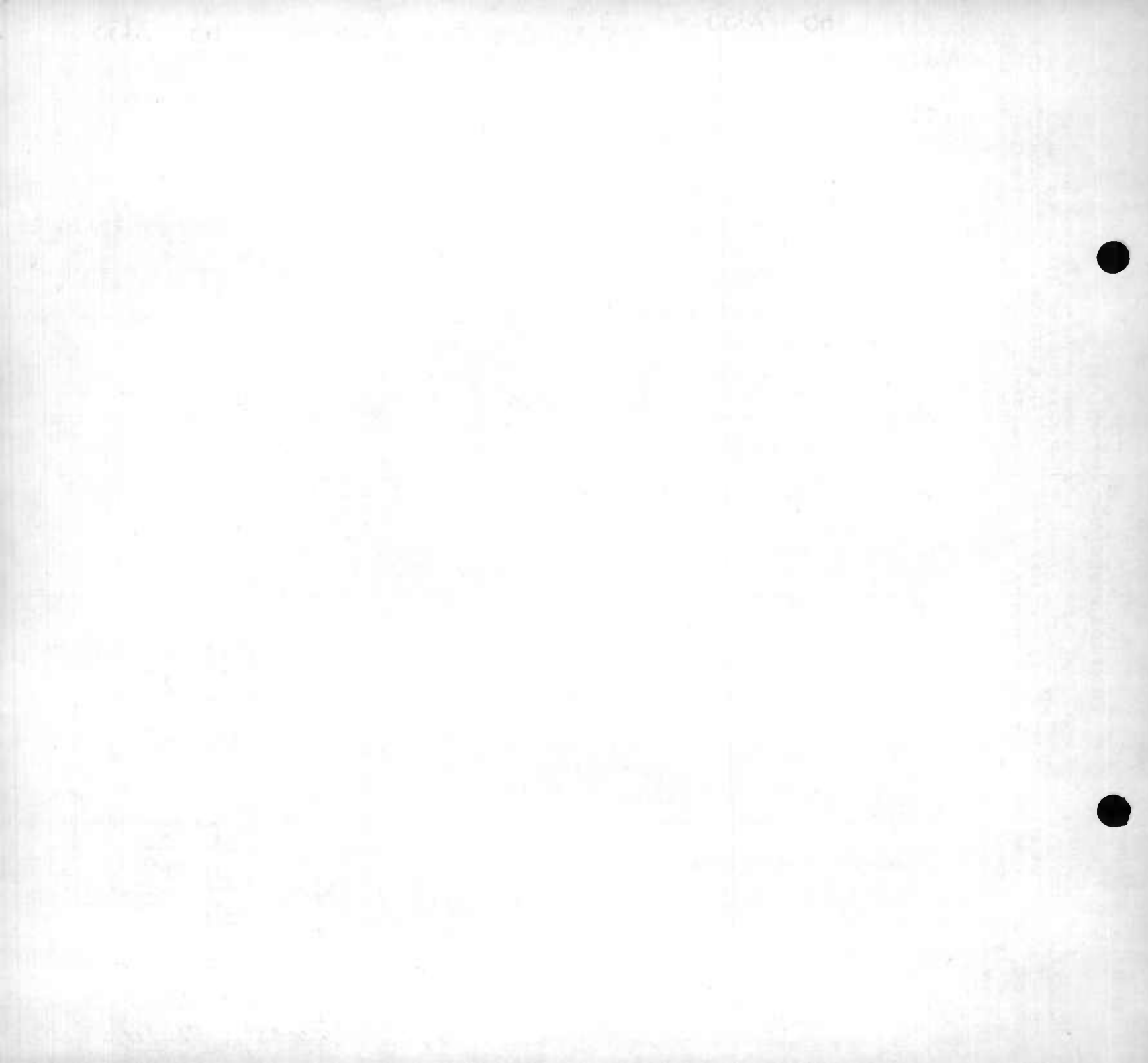
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7354 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7354 | |
|--|---------------------|--|-------------------------------------|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Laura Mary Dunphy | | | | 2. DATE AND HOUR OF DEATH
July 14, 1965 | | 6:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
US Public Health Service Hospital
Wyman Pk. Drive & 31st St. | | | | A. STATE
Md. | | B. COUNTY
Balto | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | 53-00 | |
| | | | | D. STREET ADDRESS (If rural, give location)
23 Lombardy Drive | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
11/11/97 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Wash. DC | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Young | | | | 14. MOTHER'S MAIDEN NAME
Ida Cumberland | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, Md. | | | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
Anteroselectic cardiovascular disease | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 12 19 65 to July 14 19 65 , that (I) (we) last saw the deceased alive on July 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Thomas J. Lau | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/14/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-17 1965 | | 24C. NAME of CEMETERY or CREMATORY
Meadowridge Mem. Park | | 24D. LOCATION (City, town, or county) (State)
Dorsey Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
John J. Duda | | ADDRESS
7922 Wise Ave. Dundalk Md. 22 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65-7355 | |
|---|---|--|--|--|---|
| BIRTH NO. 65 7355 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Hardy, Wilbert | | 2. DATE AND HOUR OF DEATH
7/12/65 2:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
38 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD.
B. COUNTY 14-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTO. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
University Hospital | | D. STREET ADDRESS (If rural, give location)
2130 Division St. | | | |
| 5. SEX
Male | 6. RACE
C. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
6/6/29 | 9. AGE (In years last birthday)
36 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | 10B. KIND OF BUSINESS OR INDUSTRY
market | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Richard Hardy | | 14. MOTHER'S MAIDEN NAME
Emma Braxton | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO.
220-246026 | | 17. INFORMANT
R. Staner | |
| 18. 204.1 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Status Asthmaticus
DUE TO
Chronic Myelocytic Leukemia & Acute Blastic Crisis | | 10 Days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) _____
DUE TO | | Months | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 7/15 19 65 to 7/12 19 65 , that (1) (we) last saw the deceased alive on 7/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Robert E. Staner M.D. | | | | 23B. DATE SIGNED
7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE
7/15/65 | 24C. NAME of CEMETERY or CREMATORY
mt Auburn | | 24D. LOCATION (City, town, or county) (State)
BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | 25B. NAME OF REGISTRAR
Robert E. Staner | | 25C. FUNERAL DIRECTOR
Wm. J. Shetman Jr. | | |
| | | | | ADDRESS
1701 Mt. Airy Rd. BALTO. MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|---|--|--|
| BIRTH NO. 65 7356 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7356 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | (Type or Print) CHARLES H WHITE | | 7/12/65 10:45 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| UNION MEMORIAL HOSPITAL | | | MD 12-86 | | |
| 44 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location) | | | E. STREET ADDRESS (If rural, give location) | | |
| | | | 321 W. 30TH STR. | | |
| 5. SEX | 6. RACE | 7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M | CAUCASIAN | | 12/9/97 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED PAINTER - SELF | | | | BALTIMORE, MD | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| EDWARD J. WHITE | | | EMMA OWENS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | ELVA UPPERCUE-321 W. 30TH ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) ACUTE PANCREATITIS 1 MONTH | | |
| II | | | (B) SEVERE PULMONARY EMPHYSEMA | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) CONGESTIVE HEART FAILURE MANY YEARS + SEVERE ARTERIO SCLEROSIS | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 16/27/65 | | PERFORATED ULCER | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| NO | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/27/65 to 7/12/65, that (I) (we) lost the deceased alive on 7/12/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Sigrid A. Heine | | | | 7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| SIGRID A. HEINE | | UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 7/16/65 | | New Cathedral | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 15 1965 | | Robert E. Fadden | | Austin E. Donovan-3818 Roland Ave | |

BIRTH NO. 65

7357

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

7357

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET FORWOOD

2. DATE AND HOUR PRONOUNCED DEAD

7/12/65 7:05 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1923 N. Collington Ave. #13

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

8/19/1907

9. AGE (in years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis F. Fetsch

14. MOTHER'S MAIDEN NAME

Grace Pruitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

George G. Forwood above - Husband

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic and hypertensive cardio-
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/15/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 15 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane #13

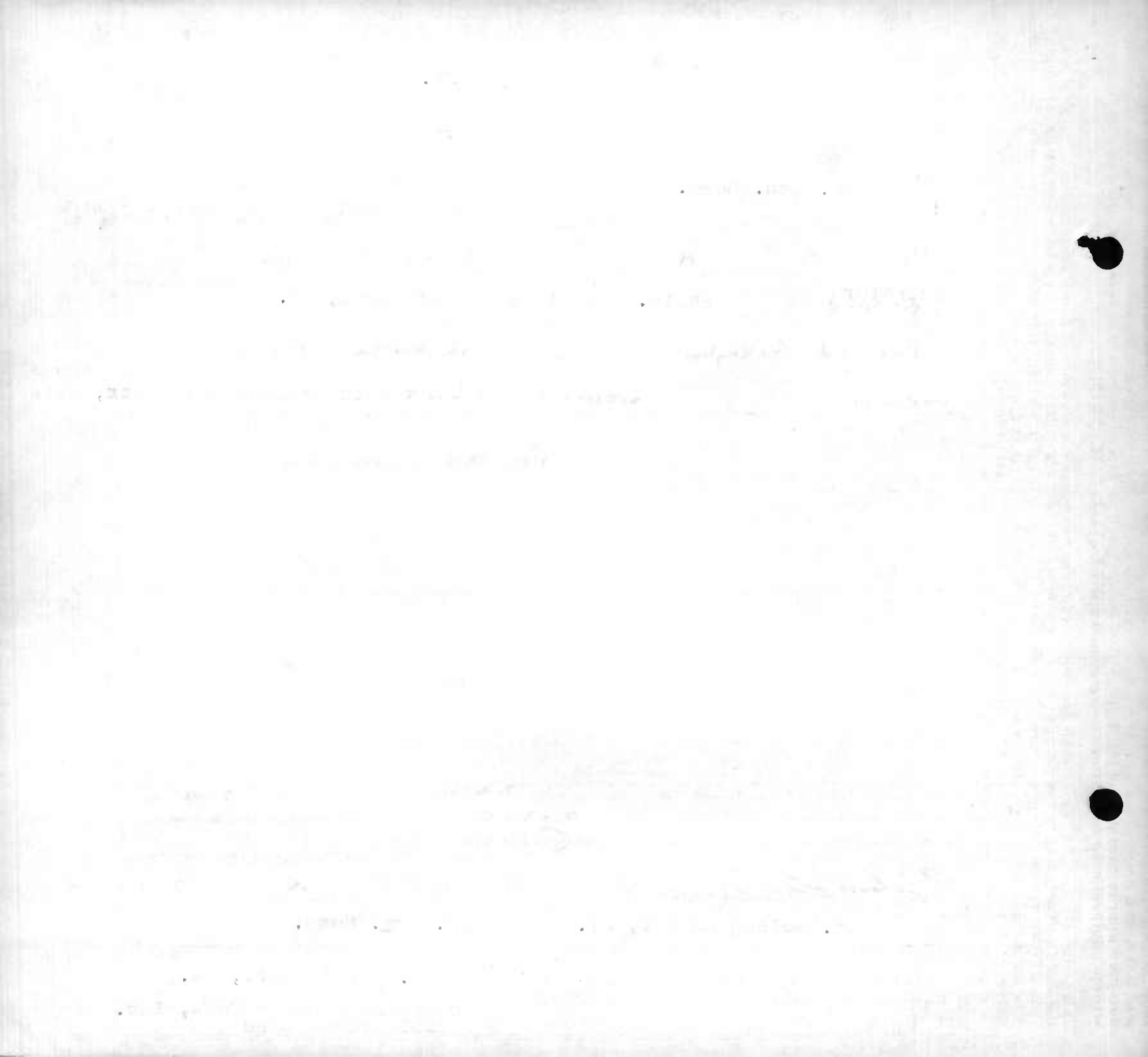
ADDRESS

WALLACE FAIRBANKS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7358 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7358 | |
|--|------------------|--|---|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mr. Bernard Gallagher Jr. | | | | 2. DATE AND HOUR OF DEATH 7-14-65 1 125 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 26-23 | |
| 48 Md. Gen. Hosp. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 3509 ELMLEY AVE. BALTO 13, MD | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 8-29-08 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Bernard Gallagher | | | 14. MOTHER'S MAIDEN NAME Roberta Francis | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown | | | 16. SOCIAL SECURITY NO. 213 100990 | | 17. INFORMANT Chart Ruth Hammann Gallagher, wife | | |
| | | | ADDRESS above | | | | |
| 18. I 177X I | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Prostatic Carcinoma | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-2-65 19 to 7-14-65 19, that (I) (we) last saw the deceased alive on 7-13-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Nelson S. Keeler Jr. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Nelson Keeler, Jr. | | | | 23D. ADDRESS Md. Gen. Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | ADDRESS 3331 Brehms Lane | |



| BIRTH NO. 65 7359 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 7359 | |
|---|-----------|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____ | | | | | |
| M.E. CASE NO. _____ | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| MINNIE B. SMITH | | | July 13, 1965 2:20 P M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
41 St. Joseph's Hospital | | | A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2926 Harford Road | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | Caucasian | widowed | 4/24/1886 | 79 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| housewife | | at home | Baltimore, Md. | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Ferd G. Laux | | | Annie Heck | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| | | 216-09-9283 | Edna W. Wilson, neice, 3330 Elmley Ave. | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic Heart Disease. | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | M.D. | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | 7/14/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | 23C. NAME of CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 7/16/65 | Loudon Park Cemetery | Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| JUL 15 1965 | | Robert E. Taylor | | Schimunek Funeral Home, Inc.
3331 Brehms Lane | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7360 | |
|--|---|--|--|--|--|
| BIRTH NO.
65 7360 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) EUGENE LEMAIRE GUILFORD | | 2. DATE AND HOUR OF DEATH
JULY 13, 1965 12:28 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

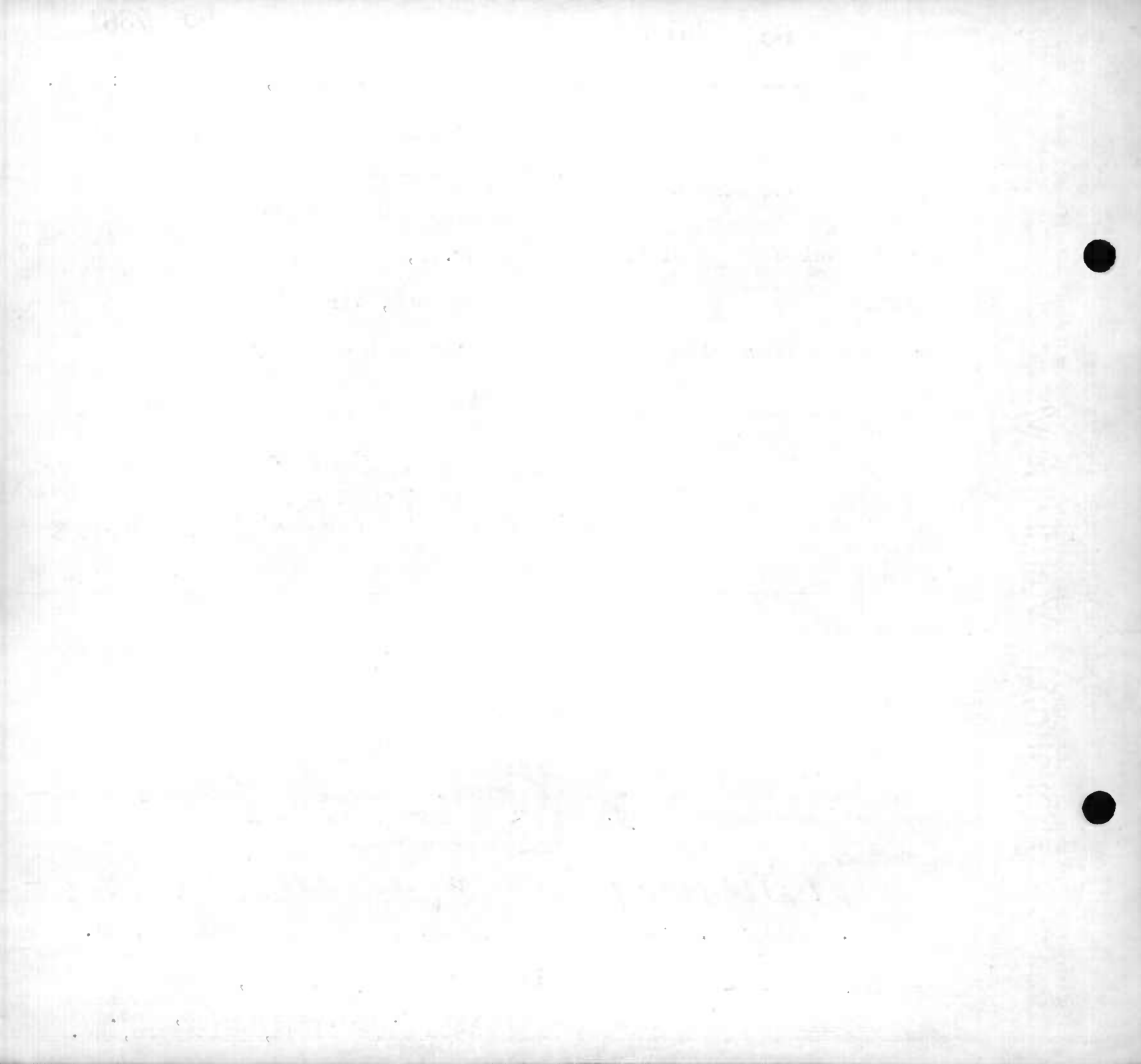
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL
44 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 12-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2721 GUILFORD AVENUE | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
2/27/85 | 9. AGE (In years lost birthday)
80 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY
Lumber Co. | | 11. BIRTHPLACE (State or foreign country)
OHIO | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
HORACE H. GUILFORD | | |
| 14. MOTHER'S MAIDEN NAME
LAURA STITT | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
HOSPITAL RECORDS | | |
| 18. 561.5 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Bronchitis and Emphysema
DUE TO
(B) Pulmonary embolism, severe
DUE TO
(C) Volvulus and segmental necrosis of small bowel
2 to 3 in. necrotic lesion | | |
| INTERVAL BETWEEN ONSET AND DEATH
pink | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION
7/11/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
VOLVULUS SMALL BOWEL WITH INCARCERATION + STRANGULATION | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (he) (this hospital) attended the deceased from 7/10 19 65 to 7/13 19 65 , that (I) (was) last saw the deceased alive on 7/13 19 65 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William R. Linton, Jr. | | | | 23B. DATE SIGNED
7/13/65 | |
| 23C. PHYSICIAN'S NAME (Type)
WILLIAM R. LINTON, JR | | | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
4-15-65 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
John O. Mitchell & Sons, Inc. | | | |
| 25D. ADDRESS
1900 Eutaw Place Baltimore, Md. | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 7361 | | Registered No. 65 7361 | |
|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Elizabeth Jarvis Winn | | | |
| 2. DATE AND HOUR OF DEATH July 12, 1965 11:50 P. M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1312 John Street | | | | A. STATE Maryland B. COUNTY 11-02 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1312 John Street | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH Aug. 2, 1891 | |
| | | | | | | 9. AGE (In years last birthday) 73 | |
| | | | | | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| | | | | 11. BIRTHPLACE (State or foreign country) Richmond, Virginia | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME Cahrles Wooster Winn | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Jane Day | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 17. INFORMANT ADDRESS Miss Mary Day Winn Same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | (A) DUE TO Congestive Heart Failure (B) DUE TO Arterio-sclerosis (C) DUE TO Cerebrovascular lateral sclerosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3-4 days Gradual onset Dec 1963 | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1964 to July 12 1965, that (I) (we) last saw the deceased alive on July 12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. William H. Woody | | | | | | 23B. DATE SIGNED 7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. William H. Woody | | | | | | 23D. ADDRESS M.D. 1403 Park Avenue Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 7-13-65 | | 24C. NAME OF CEMETERY or CREMATORY Green Mount | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc. 1900 Eutaw Place, Baltimore, Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in the hospital. If the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------|---|---|---|---|
| BIRTH NO. A-600 65 7362 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7362 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ELEANORA BARBARA AIREY | | | 2. DATE AND HOUR OF DEATH 7-13-65 12 45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 7-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 5 D. STREET ADDRESS (If rural, give location) 515 N. CASTLE ST. | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 12-21-93 | 9. AGE (In years lost birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JACK WACKER | | 14. MOTHER'S MAIDEN NAME WILHEMIA HOERL | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Mildred Souvenir - 2202 Orleans St. | |
| 18. 287X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) cardiac arrest DUE TO (B) carbon dioxide narcosis DUE TO (C) Pickwickian syndrome | | INTERVAL BETWEEN ONSET AND DEATH 3 min ~ 1 week ? years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — | | | | | |
| 19A. DATE OF OPERATION 2 — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? — | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10 19 65 to 7/13 19 65, that (I) (we) last saw the deceased alive on 7/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert I. Keimowitz M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 7/13/65 | |
| 23C. PHYSICIAN'S NAME (Type) Robert I. Keimowitz M.D. | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 7-16-65 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM. | |
| 24D. LOCATION BALTO. - MD. | | 24E. LOCATION (City, town, or county) (State) | | 24F. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR Stanley Miller - 2334 Jefferson St. | |
| 25D. ADDRESS | | | | | |

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1919

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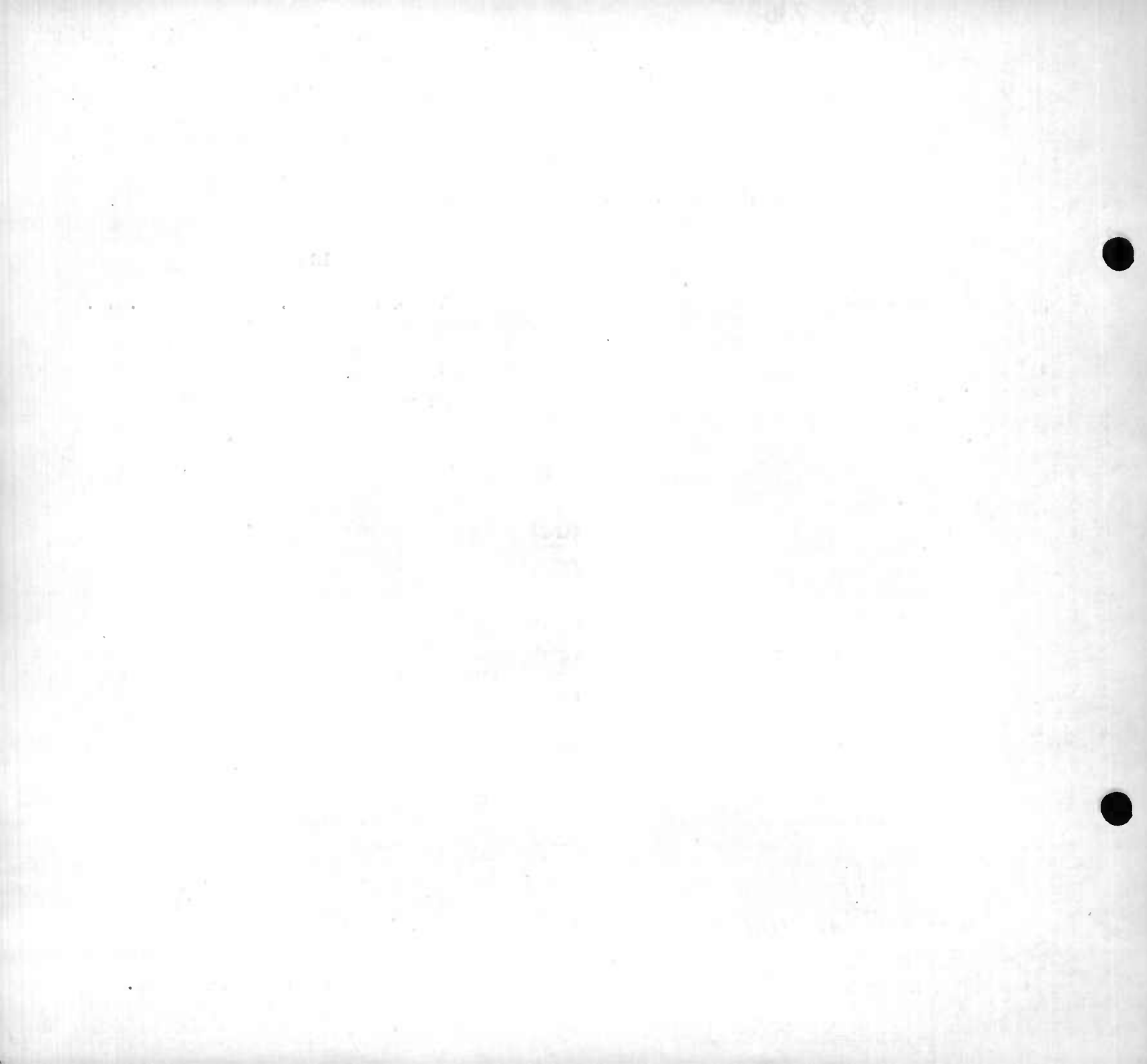
1921

1922

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. <u>65-7363</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>116-25-63</u> | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 65-7363 | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | A. M. | |
| SPAZIANI, Robert J. JR | | 7/12/65 | | 10 ¹⁰ | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | B. COUNTY | | PA | |
| THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | W CHESTER PA | |
| | | D. STREET ADDRESS (If rural, give location) | | 321 W BIDDLE ST | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months: Days: Hours: Min. |
| Male | WHITE | | 12-29-63 | 167 MONTHS | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Never Worked | | | | West Chester Penna. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| SPAZIANI ROBERT SR. | | SARA MOORE | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Father as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Progressive brain deterioration | | 8 mos | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (his hospital) attended the deceased from 6/29 1965 to 7/12 1965, that (I) (we) lost saw the deceased alive on 7/12 1965 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Norman Fost | | | | 7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| NORMAN FOST | | JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Removal | 7/12/65 | | | West Chester Penna. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 15 1965 | Robert E. Farley, M.D. | William J. Zickner + Sons North + Park | | | |



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65 7364

BALTIMORE CITY HEALTH DEPARTMENT

65 7364

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | |
|---|-----------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print)
EDWIN M. WANNEN | | 2. DATE AND HOUR PRONOUNCED DEAD
July 13, 1965 7:05 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
48 Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 11-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
Alcazar Hotel, Cathedral & Madison | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
October 10, 1900 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
64 |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George R. Wannen | | 14. MOTHER'S MAIDEN NAME
Ida Keidel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mr. Carl L. Wannen | | ADDRESS
618 St. Francis Rd. 4 | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
(A) Fatty Liver and Arteriosclerotic Cardiovascular Disease.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Acute Ethylism. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/14/65
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23B. DATE
July 16, 1965 | |
| 23C. NAME of CEMETERY or CREMATORY
Lorraine Park Cemetery | | 23D. LOCATION (City, town, or county) (State)
Woodlawn Md. | |
| 24A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 24B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 24C. FUNERAL DIRECTOR
Wm. L. Pickner & Sons 7114 Ave. 17-118 | | 24D. ADDRESS | |

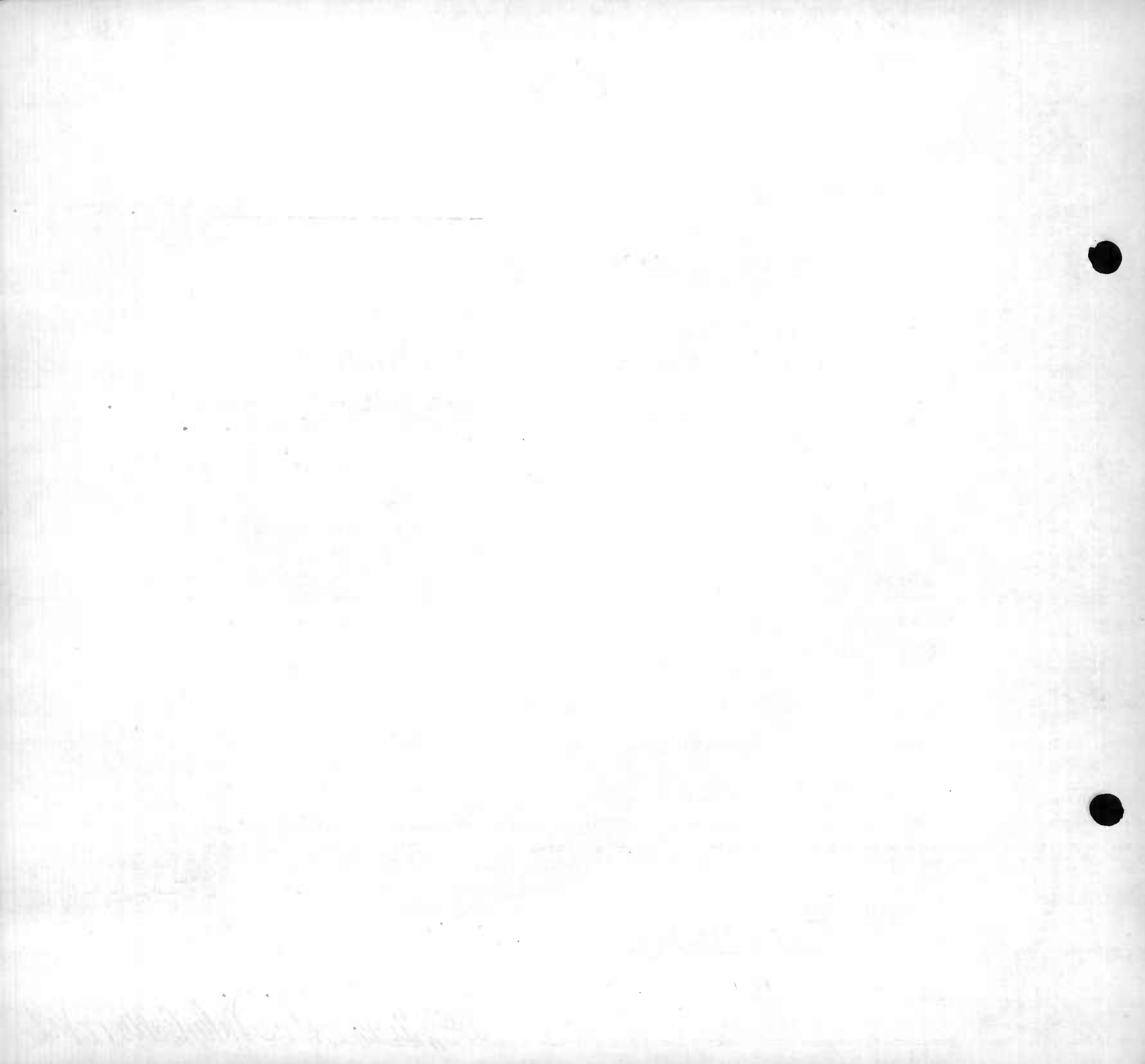
WALLACE & BOOTH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---|--|--|--|---|
| BIRTH NO. 65-19967 7365 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7365 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED
(Type or Print) <i>Teague, Baby Boy Anthony</i> | | |
| 2. DATE AND HOUR OF DEATH
<i>7/13/65 3:25 P.M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>38 University Hosp</i> | | | A. STATE <i>Maryland</i>
B. COUNTY <i>11-01</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | |
| | | | D. STREET ADDRESS (If rural, give location)
38 University Hosp <i>901 N. Calvert St.</i> | | |
| 5. SEX
<i>Male</i> | 6. RACE
<i>White</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Single</i> | 8. DATE OF BIRTH
<i>7-12-65</i> | 9. AGE (In years last birthday)
<i>20</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> |
| 13. FATHER'S NAME
<i>Schakib Teague</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Patricia McClary</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS
<i>Gerald McClary 104 Meadowspring Rd.</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
<i>Richmond, Va.</i>
<i>Pul. & Pleural + Respiratory distress</i>
<i>Prematurity</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2</i> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 12, 1965</i> to <i>July 13, 1965</i> , that (I) (we) last saw the deceased alive on <i>July 13, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <i>not</i> view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Earlie H. Francis</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>7-13-65</i> |
| 23C. PHYSICIAN'S NAME (Type)
<i>Earlie H. Francis</i> | | | 23D. ADDRESS
<i>University Hosp.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Removal</i> | 24B. DATE
<i>7/14/1965</i> | 24C. NAME OF CEMETERY or CREMATORY
<i>Washington Memorial</i> | 24D. LOCATION (City, town or county) (State)
<i>Richmond, Va.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 15 1965</i> | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | 25C. FUNERAL DIRECTOR
<i>Wm J. Lickens</i> | | ADDRESS
<i>1717 N. Calvert St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7366 | |
|---|-------------------------|---|-------------------------------------|--|--|
| BIRTH NO. 65 7366 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) ROSE ELIZABETH RHODE | | 2. DATE AND HOUR OF DEATH
JULY 14, 1965 2:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 UNION MEMORIAL HOSPITAL | | A. STATE MARYLAND
B. COUNTY 28-04 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location)
306 ATHOL AVENUE | | | |
| 5. SEX
F | 6. RACE
CAUC. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-26-01 | 9. AGE (In years lost birthday)
63 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | 13. FATHER'S NAME
BENJAMIN EBERINGHAM | | 14. MOTHER'S MAIDEN NAME
FLORENCE WICKES | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
UNKNOWN | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mr. Russell M. Rhode 306 Athol Ave. 29, Md. | |
| 18. 199.1 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) METASTATIC SARCOMA RT. SHOULDER
DUE TO
metastasis to Lungs | | | |
| ANTECEDENT CAUSES | | (B) RESPIRATORY DISTRESS
DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) with massive pulmonary effusion | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Yes | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAY 29 1965 to JULY 14 1965 , that (I) (we) last saw the deceased alive on JULY 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Samuel C. Gresham | | | | 23B. DATE SIGNED
July 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
SAMUEL C. GRESHAM | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
July 16 1965 | | 24C. NAME of CEMETERY or CREMATORY
Loudon | |
| 24D. LOCATION
Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Wood Tucker & Sons N.Y.C. 17-Md. | | | |

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

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65 7367

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7367

| | | | |
|---|--|---|--|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| (GEORGE W. BECKMYER)
GEORGE BECKMEYER | | July 13, 1965 7:30 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE
Maryland | |
| Baltimore City Hospitals | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore | |
| | | D. STREET ADDRESS (If rural, give location)
1749 Darley Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| Male | Caucasian | MARRIED | MARCH 14, 1885 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| Water Dept. Balto. City | | Retired | Baltimore, Maryland |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Walter L. Beckmyer | | Emma F. Hunter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| NO | | NONE | |
| 17. INFORMANT | | ADDRESS | |
| Mr. C. Raymond Knipp | | 2523 Hamilton Avenue | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | |
| E 900.9 + 163X
Bronchopneumonia | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) DUE TO | |
| Carcinoma of Lung; Arteriosclerotic Heart Disease; Pulmonary Emphysema. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | Yes | Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| | | Home | 1749 Darley Avenue |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | Fell down stairs. | |
| 7 | 9 '65 P | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | DATE SIGNED | |
| Charles S. Petty, M.D. | | 7/14/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) |
| Burial | 7/16/65 | Baltimore Cemetery | Baltimore Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR ADDRESS |
| JUL 15 1965 | | Henry Sander & Sons Inc. | Baltimore Maryland 21213 |

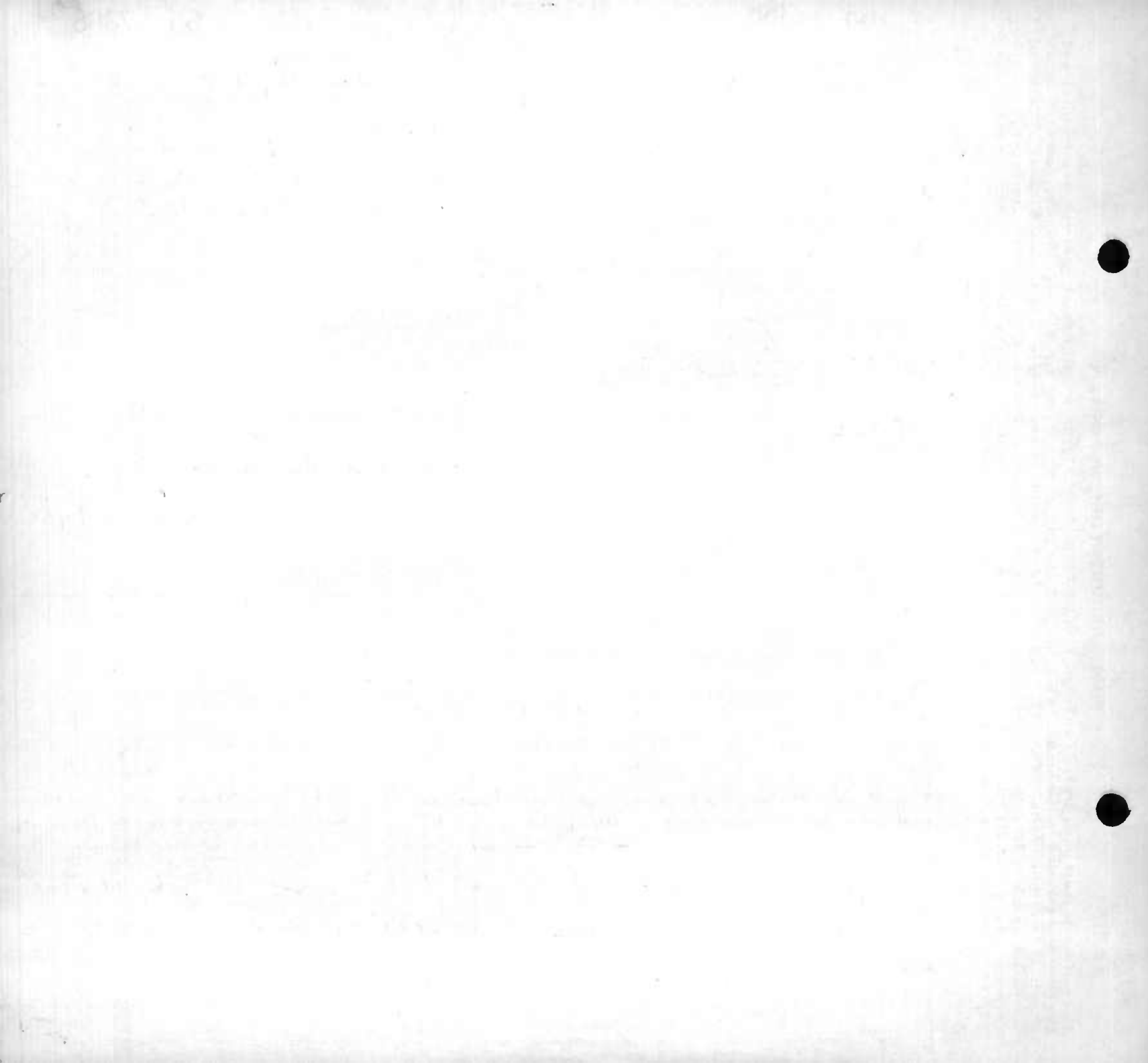
WALTER CONGLE

Charles

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

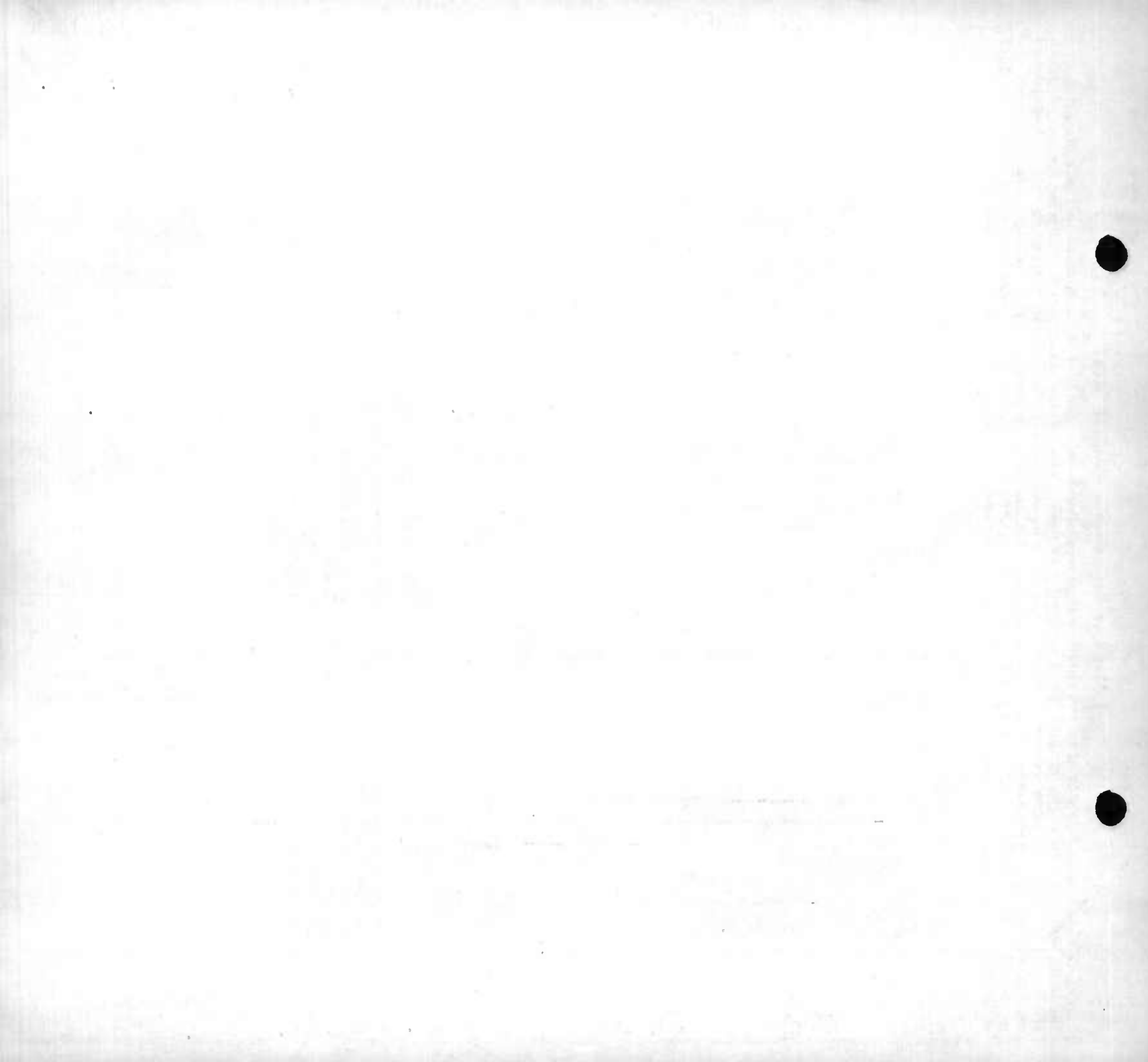
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Baltimore City Health Department | |
|---|---------------------|--|---|---|--|
| F625 65 7368 | | | | Registered No. 65 7368 | |
| BIRTH NO. | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED
(Type or Print) LULA FERGUSON | | | | 2. DATE AND HOUR OF DEATH
JULY 13, 1965 645 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
38 University Hospital | | | | A. STATE MARYLAND B. COUNTY 28-02 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location)
5316 FERN PARK AVE. | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
W | 8. DATE OF BIRTH
Nov. 03, 1900 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country)
Johnson N. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Neal Ferguson | | | 14. MOTHER'S MAIDEN NAME
Lula Davis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Clarine Nelson |
| | | | ADDRESS
Samuel | | |
| 18. 2040 I | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) | | | (A) BILATERAL LOBAR PNEUMONIA
DUE TO | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) CHRONIC LYMPHATIC LEUKEMIA
DUE TO 79 yrs. | | |
| | | | (C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 6, 1962 to July 13, 1965 , that (I) (we) last saw the deceased alive on July 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Martin C. Sharzel M.D. | | | | 23B. DATE SIGNED
July 13, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
MARTIN C. SHARZEL M.D. | | | | 23D. ADDRESS
UNIVERSITY HOSPITAL, BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-18-1965 | | 24C. NAME OF CEMETERY or CREMATORY
Carver Cent | |
| 24D. LOCATION (City, town, or county) (State)
Lanval Cent Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
Shoy O. Wilson - 1000 Brantley Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 65 7369 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7369 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <i>Margaret Wohler</i> | | |
| 2. DATE AND HOUR OF DEATH <i>July 13, 1965 1:20 A.M.</i> | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>905</i> | | (If not in hospital or institution, give street address or location) <i>905 Caton Avenue</i> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-01</i> | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>905 Caton Avenue</i> | | 5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | |
| 8. DATE OF BIRTH <i>2/16/1887</i> | | 9. AGE (In years lost birthday) <i>84</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>William Elberskirch</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Anna Kurtz</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>Mrs. Esther Parlett</i> | | ADDRESS <i>905 Caton Ave.</i> | | 18. <i>443X1</i> CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Cerebral hemorrhage with hemiplegia (right)</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs.</i> | |
| ANTECEDENT CAUSES | | (B) <i>Hypertension arteriosclerotic cardiovascular disease</i> | | <i>5 yrs.</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) _____ | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 19 63</i> to <i>July 13, 1965</i> , that (I) (we) last saw the deceased alive on <i>July 10 19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Lloyd E. Saylor</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>July 13, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i> | | 23D. ADDRESS <i>3902 Greenmount Ave., Balto, Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>7/16/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> | | 24E. DATE REC'D BY HEALTH DEPT. <i>JUL 15 1965</i> | | 24F. NAME OF REGISTRAR <i>Robert E. Farley</i> | |
| 24G. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i> | | 24H. ADDRESS <i>3000 E. Baltimore St.</i> | | | |

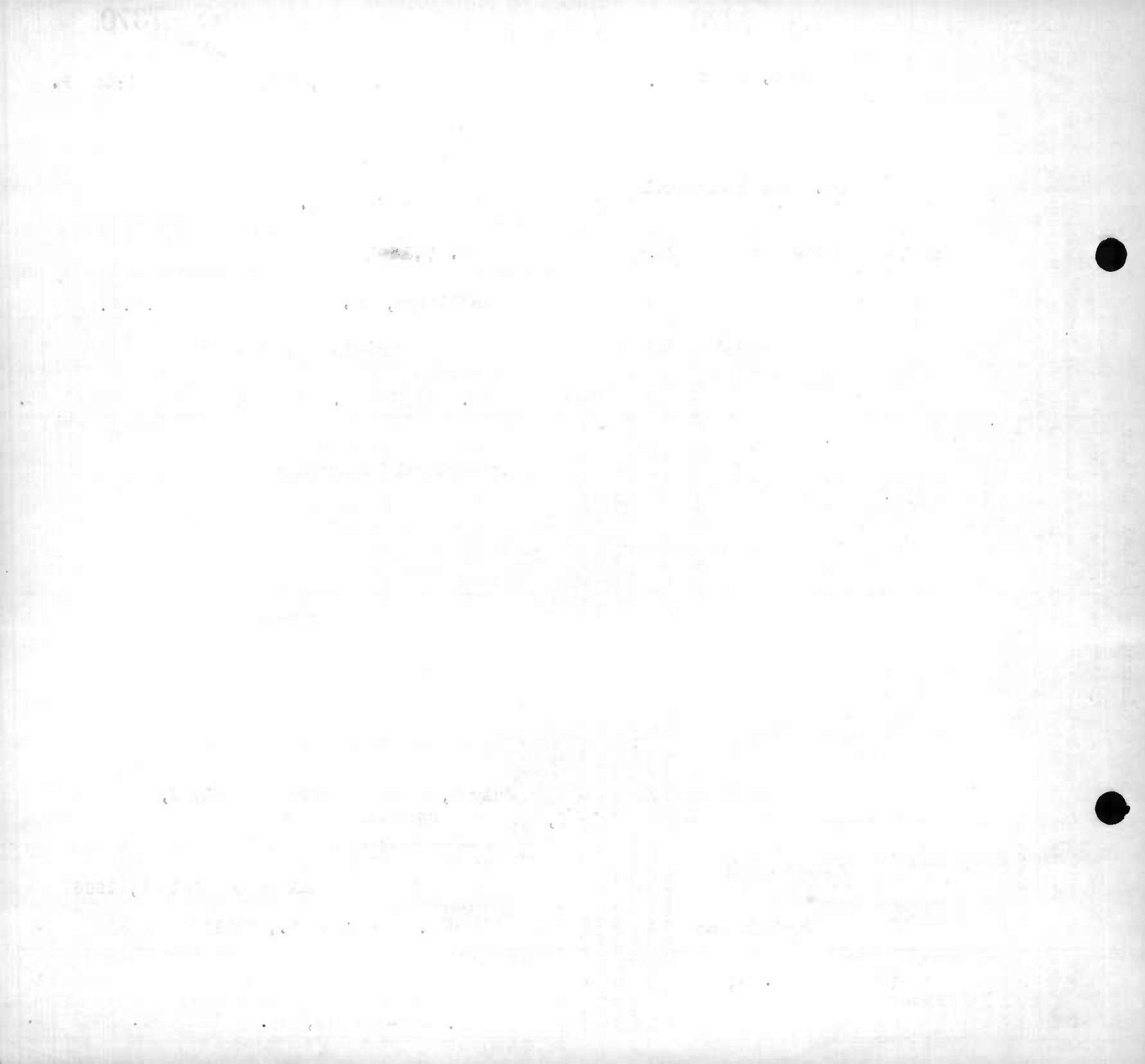


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|--|--|--|
| BIRTH NO. 65 7370 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7370 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Laye, Agnes V. | | 2. DATE AND HOUR OF DEATH
July 3, 1965 1:05 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

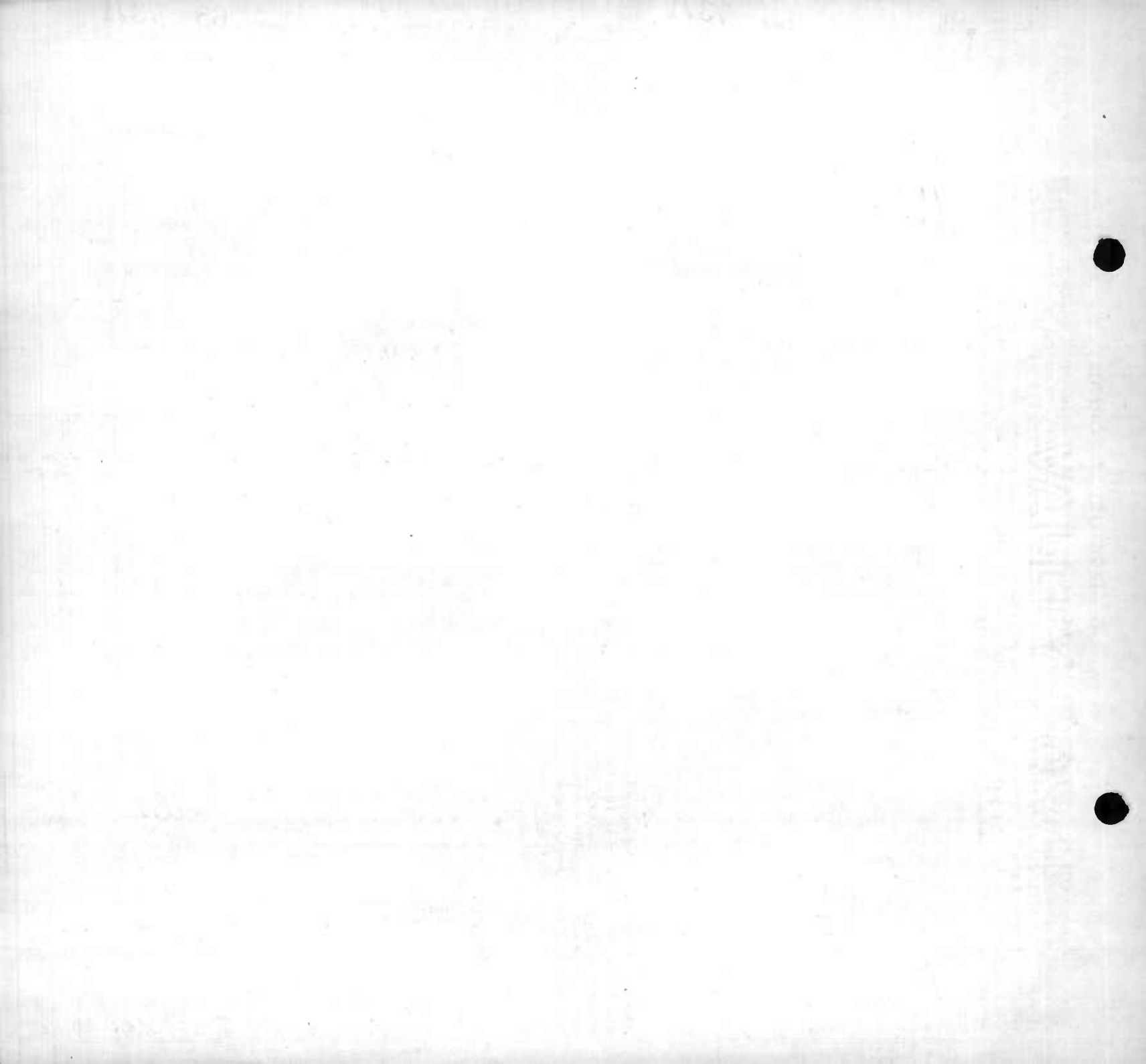
FULL NAME OF HOSPITAL OR INSTITUTION
St. Joseph Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 27-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore #6
D. STREET ADDRESS (If rural, give location)
4120 Moravia Blvd. | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
Nov. 27, 1891 | 9. AGE (In years lost birthday)
73 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
(Unknown) Redgrave | | 14. MOTHER'S MAIDEN NAME
Harriett (Unknown) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS (30)
Mrs. Lillian F. Paulsen 1437 Woodall St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Intracerebral hemorrhage | | CAUSE OF DEATH
Intracerebral hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | MEDICAL CERTIFICATION
CERTIFICATION APPROVED BY
<i>[Signature]</i>
CHIEF OF DIST. MEDICAL EXAMINER | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from July 3, 19 65 to July 3, 1965 , that (I) (we) last saw the deceased alive on July 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE
<i>[Signature]</i>
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23B. DATE SIGNED
July 3, 1965 | | 23C. PHYSICIAN'S NAME (Type)
Govinda Rao | | 23D. ADDRESS
M.D. 1400 N. Caroline St., 21213 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
July 7, 65 | | 24C. NAME of CEMETERY or CREMATORY
Western Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
<i>[Signature]</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7371 | |
|---|--|--|--|---|--|
| BIRTH NO. 65 7371 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARGARET E. SMITH | | 2. DATE AND HOUR OF DEATH
July 6, 1965 11⁰⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD B. COUNTY Balto | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Gould Nursing Home | | D. STREET ADDRESS (If rural, give location)
8923 SATYR Hill Rd | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
nt home | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 8. DATE OF BIRTH July 6 1906 9. AGE (In years last birthday) 59 | |
| 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Tully M. Lewis | |
| 14. MOTHER'S MAIDEN NAME
Lenore Lewis | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
Family Records | | ADDRESS | | 18. 5-02.11 CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute Purulent Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
48 hr | | 19. Chronic Laryngo Tracheo Bronchitis & Tracheostomy | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Bedfast old fractured hip & underlying multiple sclerosis | | 10YR. DATE OF OPERATION
NO | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | |
| 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from March 19 65 to July 19 65 , that (I) (we) last saw the deceased alive on July 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE
Frank P. Kasik | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/7/65 | |
| 23C. PHYSICIAN'S NAME (Type)
FRANK KASIK MD | | 23D. ADDRESS
9605 Hartford Road | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | |
| 24B. DATE
7-10-65 | | 24C. NAME of CEMETERY or CREMATORY
GARDENS of FAITH Balto Co MD | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
C. F. EVANS & SON | |
| ADDRESS
8862 Harting Rd | | | | | |



FUNERAL DIRECTOR: IMPORTANT

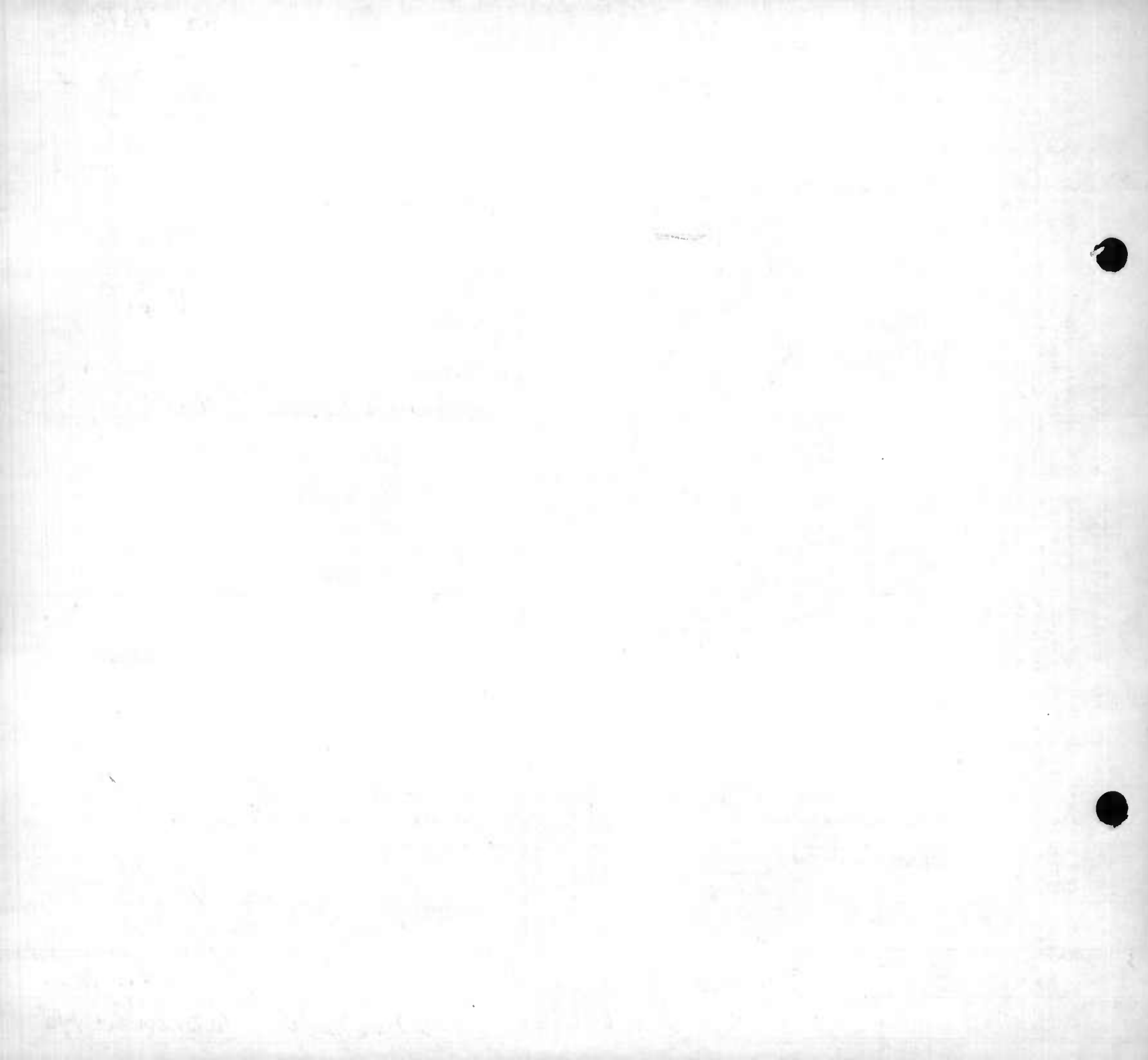
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 75985 7372 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7372 | |
| M.E. CASE NO. 75985 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Russell C. Crist | | | 2. DATE AND HOUR OF DEATH
6/28/65 17:10 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Bon Secours Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MD B. COUNTY Howard
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Ellicott City
D. STREET ADDRESS (If rural, give location)
Bethany Lane | | |
| 5. SEX
Male | 6. RACE
White | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
3-8-93 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
George Crist | | | 14. MOTHER'S MAIDEN NAME
Julia Davis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | ADDRESS
Mr Russell C. Crist - Ellicott City - Md | |
| 18. I 1810 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

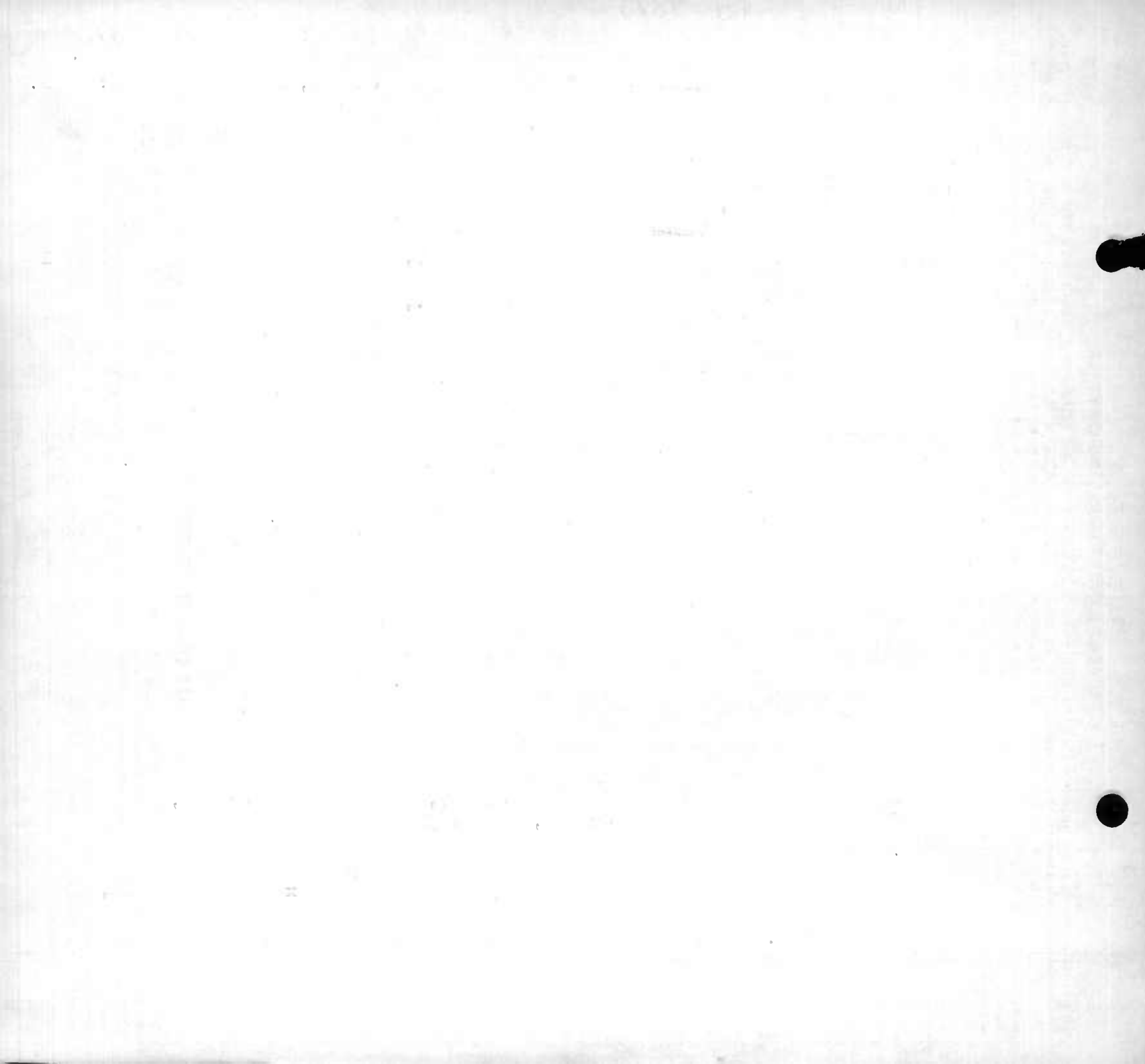
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
(A) Ca. of urinary bladder
DUE TO with Metastasis
(B) DUE TO
(C) | | |
| 19A. DATE OF OPERATION
6/28/65 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on June 28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Tai | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
6/28/65 |
| 23C. PHYSICIAN'S NAME (Type)
Tse-Wu Tai | | | 23D. ADDRESS
Bon Secours Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
July 1-1965 | | 24C. NAME OF CEMETERY or CREMATORY
Meadowridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Ellicott City - Howard Co. Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR
E. S. MacNabb | |
| | | | | ADDRESS
Catonville Md | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

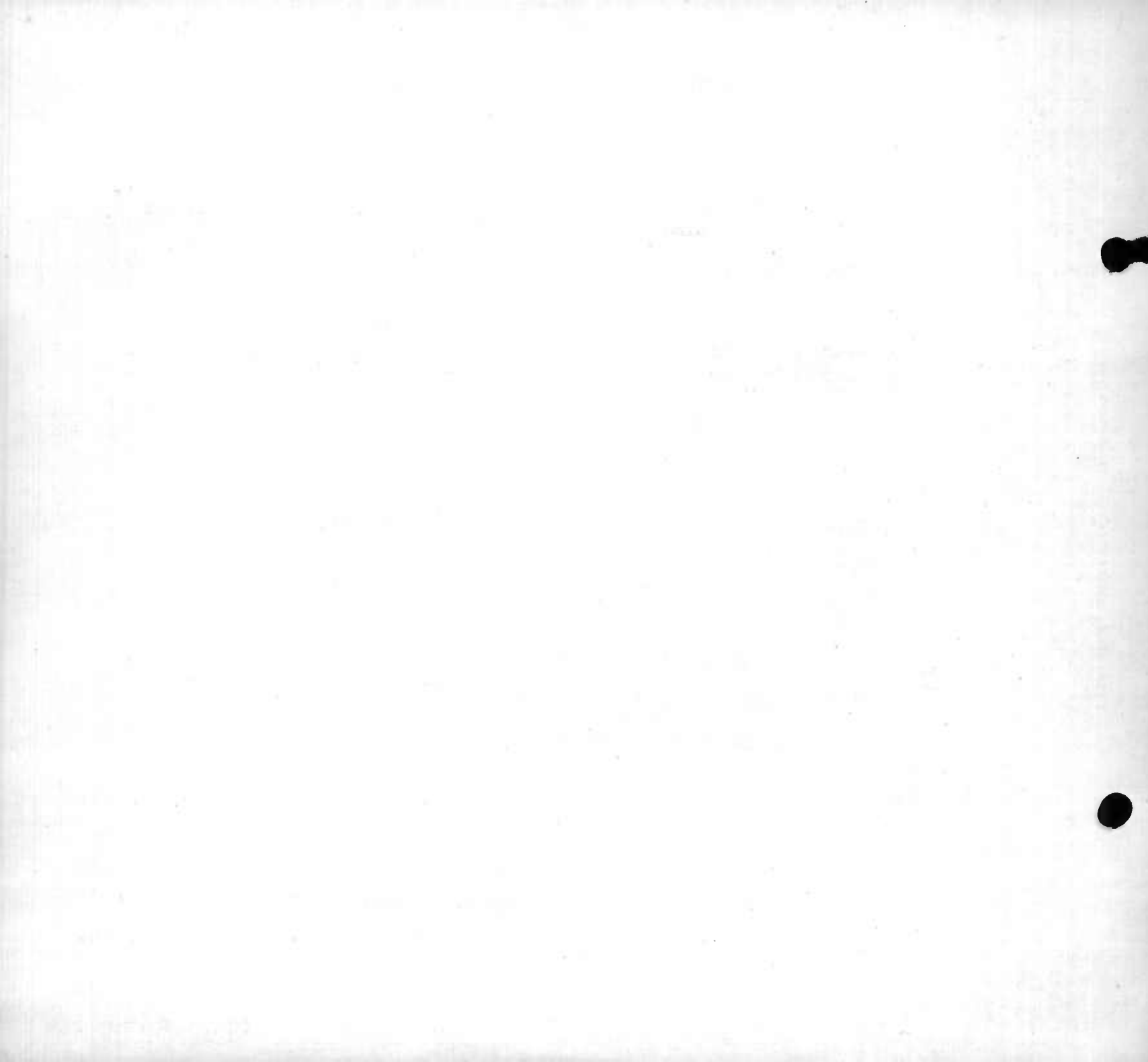
| | | | | | |
|---|--|----------------------------------|--|------------------------|--|
| BIRTH NO. 65-17350 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7373 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Bay Baby Barbara Gill | | | July 8, 1965 11:35 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | A. STATE Maryland
B. COUNTY Baltimore | | |
| 5. SEX Male | | | 6. RACE Negro | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | | 8. DATE OF BIRTH July 7, 1965 | | |
| 9. AGE (In years last birthday) 39 | | | 10. BIRTHPLACE (State or foreign country) Balto., Maryland | | |
| 11. BIRTHPLACE (State or foreign country) Balto., Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Charles Glenn | | | 14. MOTHER'S MAIDEN NAME Barbara Gill | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
762.57
Respiratory Distress Syndrome | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atelectasis Neonatorum | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia | | | | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) Yes. | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7, 1965 19 to July 8, 1965, that (I) (we) last saw the deceased alive on July 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Vincent R. Blake | | | 23B. DATE SIGNED July 12, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) Vincent R. Blake | | | 23D. ADDRESS M.D. 1514 Division Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) JUL 13 1965 | | | 24B. DATE JUL 13 1965 | | |
| 24C. NAME OF CEMETERY OR CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | | 25B. NAME OF REGISTRAR Robert E. Faldut | | |
| 25C. FUNERAL DIRECTOR | | | ADDRESS | | |
| ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

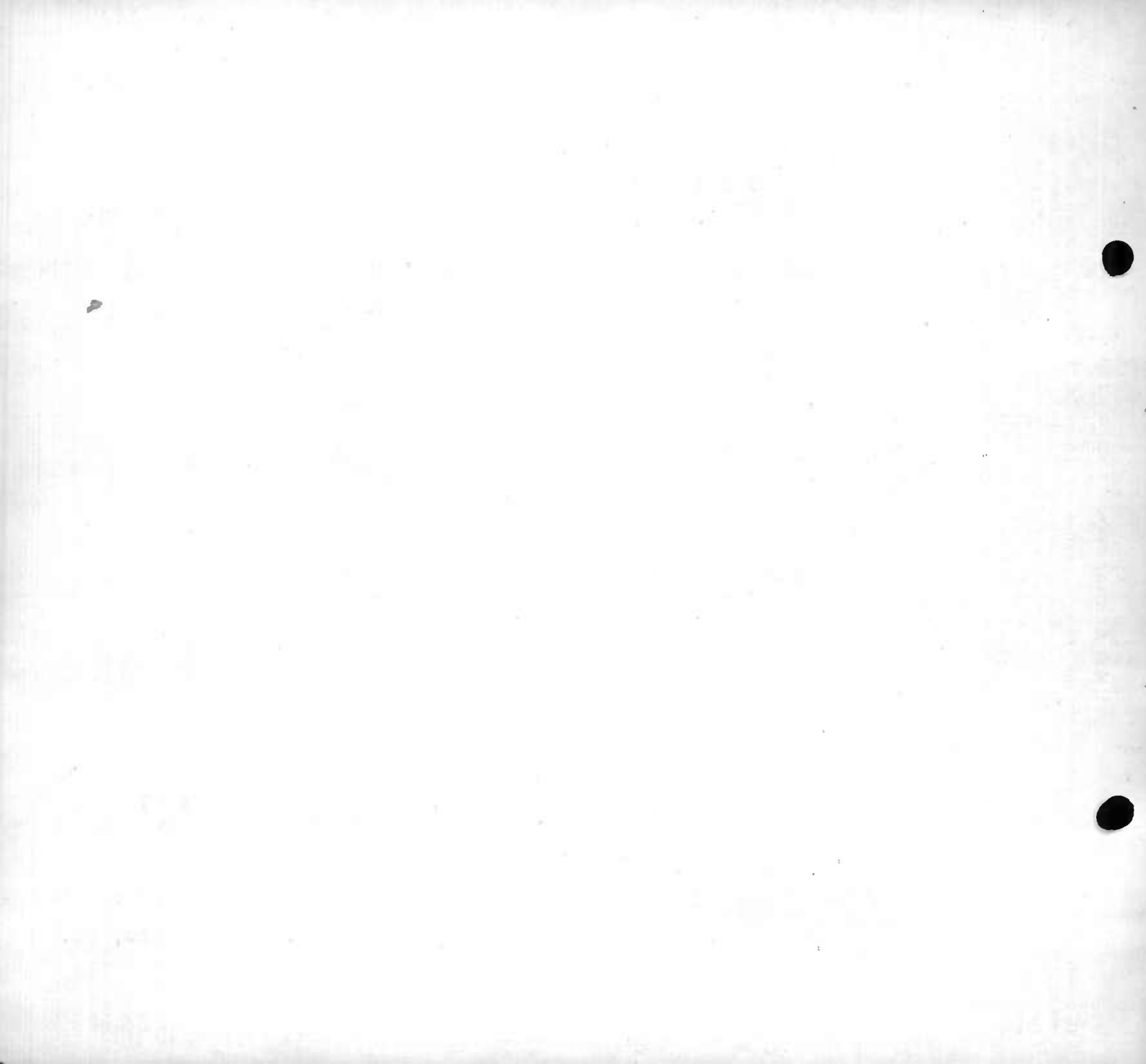
| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 65-16478 | | | | 65 7374 | | | | 65 7374 | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | Baby Willie White | | | | July 7, 1965 9:30p ^m | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 39 Provident Hospital | | | | Maryland | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 1514 Division Street | | | | Baltimore | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Baltimore, Maryland | | | | 1928 W. Mulberry Street | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| Male | | negro | | single | | July 7, 1965 | | | | 35 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| none | | | | none | | | | Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| USA | | | | Sylvester White | | | | Willie Mae Holley | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| | | | | | | | | Willie Mae White same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Neonatal atelectasis DUE TO | | | | | | | |
| ANTECEDENT CAUSES | | | | (B) due to immaturity DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 0 | | | | no | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7, 1965 19 to July 7, 1965, that (I) (we) last saw the deceased alive on July 7, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | | | |
| Lionel C. Rose | | | | | | | | July 8, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | | | |
| Lionel C. Rose | | | | M.D. 1514 Division St. Baltimore, Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town or county) | | (State) | | | |
| | | JUL 13 1965 | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | | |
| JUL 15 1965 | | Robert E. Feltus | | | | MORTUARY SERVICE - BCHD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

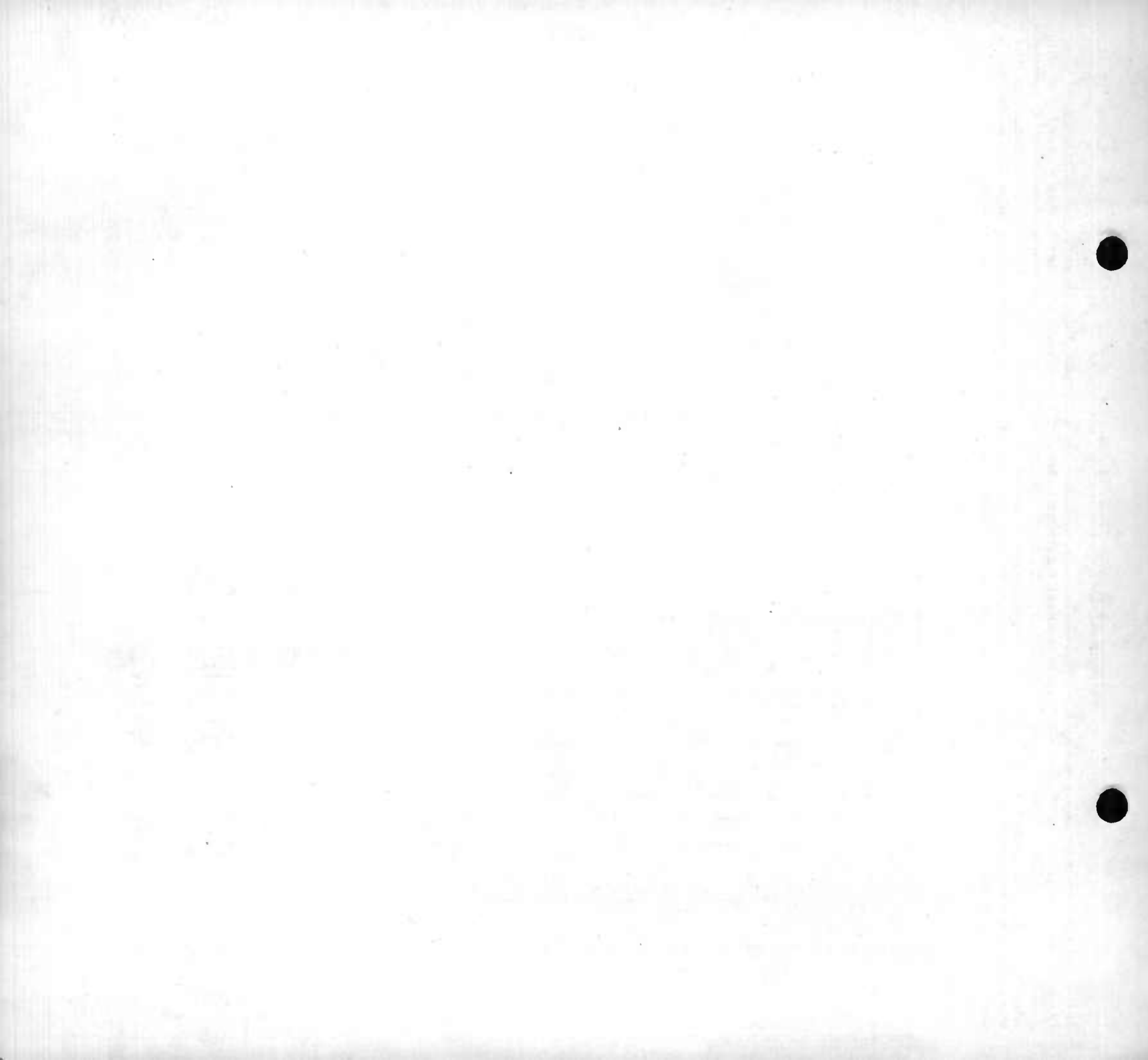
| BIRTH NO. B-670 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7375 | |
|---|--|-----------------------------------|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Baby Frances Brooks | | July 7, 1965 10:30p M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 39 Provident Hospital
1514 Division Street
Baltimore, Maryland 21217 | | | | Maryland | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | Baltimore | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| Male | | negro | | single | | 8. DATE OF BIRTH | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| none | | none | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Ronald Wilson | | | | Frances Brooks | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Frances Brooks same | |
| 18. 762,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) Massive aspiration syndrome | | | |
| ANTECEDENT CAUSES | | | | DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) due to Post maturity | | | |
| (C) | | | | DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7, 19 65 to July 7, 19 65, that (I) (we) last saw the deceased alive on July 7, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| Lionel C. Rose | | | | | | July 8, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | |
| Lionel C. Rose | | | | | | M.D. 1514 Division St. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY | | 24D. LOCATION (City, town, or county) (State) | |
| | | JUL 13 1965 | | ANATOMY BOARD OF MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 15 1965 | | Robert E. Taylor | | MORTUARY SERVICE | | BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|-----------------------------------|---|---|
| BIRTH NO. 65 7376 | | Baltimore City Health Department | | Registered No. 65 7376 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) BABY GIRL LEAP | | 2. DATE AND HOUR OF DEATH
7/4/65 4:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Towson 21204 53.00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
44 Union Memorial Hosp. | | D. STREET ADDRESS (If rural, give location)
1015-B Donnington Cir. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
7/4/65 | 9. AGE (In years lost birthday)
2 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME
PAUL LEAP | | 14. MOTHER'S MAIDEN NAME
Emilia DA ROZA | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 776X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
IMMATURITY
Prematurity | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
2 hours | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from BIRTH 7/4 19 65 to 4:05 pm 7/4 19 65 , that (I) (we) last saw the deceased alive on 4:05 pm 7/4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. L. Ledesma M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/4/65 | |
| 23C. PHYSICIAN'S NAME (Type)
ERNESTO L. LEDESMA | | 23D. ADDRESS
Union Memorial Hosp. | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
JUL 13 1965 | | 24B. DATE
JUL 13 1965 | | | |
| 24C. NAME OF CEMETERY
ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (City, town or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |

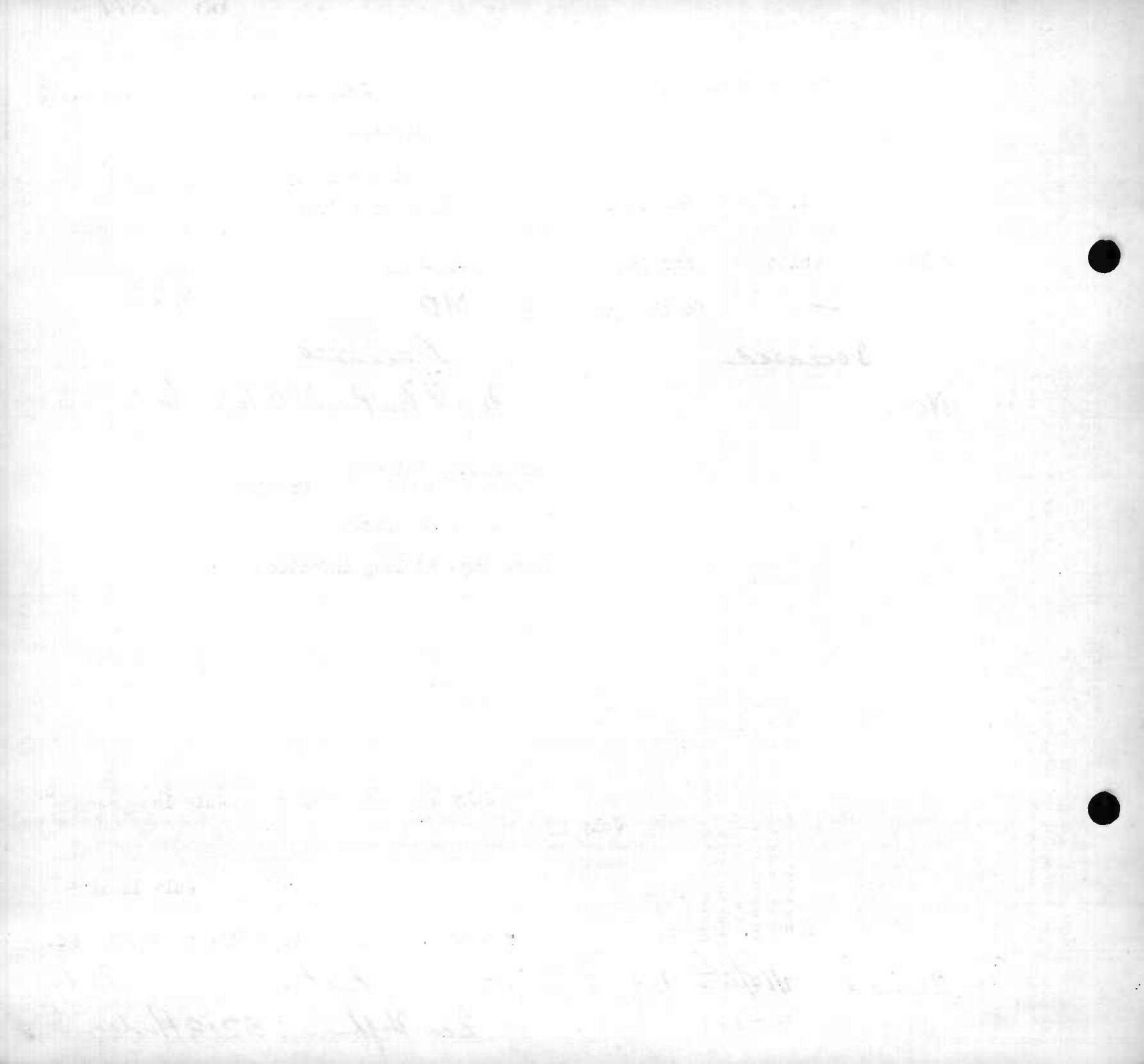


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7377 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 7377 | |
|--|-----------------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) Powell, Jesse KENDALL | | | | 2. DATE AND HOUR OF DEATH
July 14 1965 6:15 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
41 St. Josephs Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland
B. COUNTY 26-44
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore 21213
D. STREET ADDRESS (If rural, give location)
1040 Iris Ave. | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
3-15-1911 | 9. AGE (In years lost birthday)
54 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Continental Can Co. | | | 11. BIRTHPLACE (State or foreign country)
MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Deceased | | | | 14. MOTHER'S MAIDEN NAME
Deceased | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. Helen Powell 1040 Iris Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
163X I
Respiratory Failure extensive pulmonary Carcinoma
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) DUE TO
Respiratory Failure extensive pulmonary Carcinoma
(B) DUE TO
Pulmonary Emphysema
(C) DUE TO
Super imposed lung infection | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 4 1965 to July 14 1965 , that (I) (we) last saw the deceased alive on July 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Elno M. Gayoso | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 14 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Elno M. Gayoso | | | | 23D. ADDRESS
M.D. 1400 N. Caroline St. Baltimore 21213 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7/14/65 | 24C. NAME OF CEMETERY or CREMATORY
Mt. Olivet | | 24D. LOCATION (City, town, or county) (State)
Bates Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Geo. Hoffmann | | ADDRESS
3218 Hudson St. | |



BIRTH NO. 65 7378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|---|---------|--|------------------|---|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| CHRISTINE SCOTT | | | | July 14, 1965 3:45 P M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
34 Bon Secour Hospital | | | | A. STATE Maryland | | | |
| | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 20-04 | | | |
| D. STREET ADDRESS (If rural, give location)
2537 Boyd Street | | | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years
last birthday) | 10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min. | | |
| Female | Negro | | Dec. 24, 1962 | 2 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Baby | | | | Baltimore Md | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Thomas Scott | | | | Mary Bennette | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | Mary Bennette | | Same | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
E929.0 | | | | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (A) Asphyxia DUE TO | | | |
| | | | | (B) Drowning. DUE TO | | | |
| | | | | (C)..... | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | Home | | 2537 Boyd Street 20-04 | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour)
7 14 '65 P | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Drowned in bath tub. | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 7/15/65 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 7-17-65 | | Mt. Albany Cem. | | Brooklyn, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 15 1965 | | Robert E. Farley, M.D. | | C. D. Wilson | | 1000 Brantley Ave. | |

WALLEN POLICE

EX-157

Chas. J. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | Baltimore City Health Department | | | | Registered No. | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 65 7379 | | | | 65 7379 | | | | 65 7379 | | | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | Registered No. | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | 30 / A.M. | | | |
| EDWARD F. O'MALLEY | | | | 7-14-65 | | | | 1 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
(If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | | 12-01 | | | |
| 37 MERRY HOSPITAL | | | | Maryland | | | | Baltimore | | | |
| 5. SEX
M | | | | 6. RACE
W | | | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | | |
| 8. DATE OF BIRTH
1913
6-15-1912 | | | | 9. AGE (In years lost birthday)
52 yrs. | | | | 10. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Controller-Customs Broker | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Gov't. Insurance | | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | |
| 13. FATHER'S NAME
Patrick F. O'Malley | | | | 14. MOTHER'S MAIDEN NAME
Rhea Thomas | | | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
220-32-3083 | | | | 17. INFORMANT
Dorothy Norris O'Malley | | | | ADDRESS
Above | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) Respiratory Arrest
DUE TO
(B) Toxic Encephalopathy ± 2 days
DUE TO
(C) Acute Ethanol Withdrawal ± 1 week | | | | INTERVAL BETWEEN ONSET AND DEATH
- | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
None | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR?
July 13 1965 to July 14 1965 | | | |
| 22. I certify that (1) (this hospital) attended the deceased from July 13 1965 and that (1) (we) last saw the deceased alive on July 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Werner Beck | | | | 23B. DATE SIGNED
July 14-65 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Werner Beck | | | | 23D. ADDRESS
Mercy Hosp., Balto., Md. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | | 24B. DATE
7-18-65 | | | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral | | | |
| 24D. LOCATION
Baltimore | | | | 24E. STATE
Md. | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | | | 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |

Letter from Mercy Hospital for Item #22
and B.C. #A-88186 - 1913 8-11-65 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

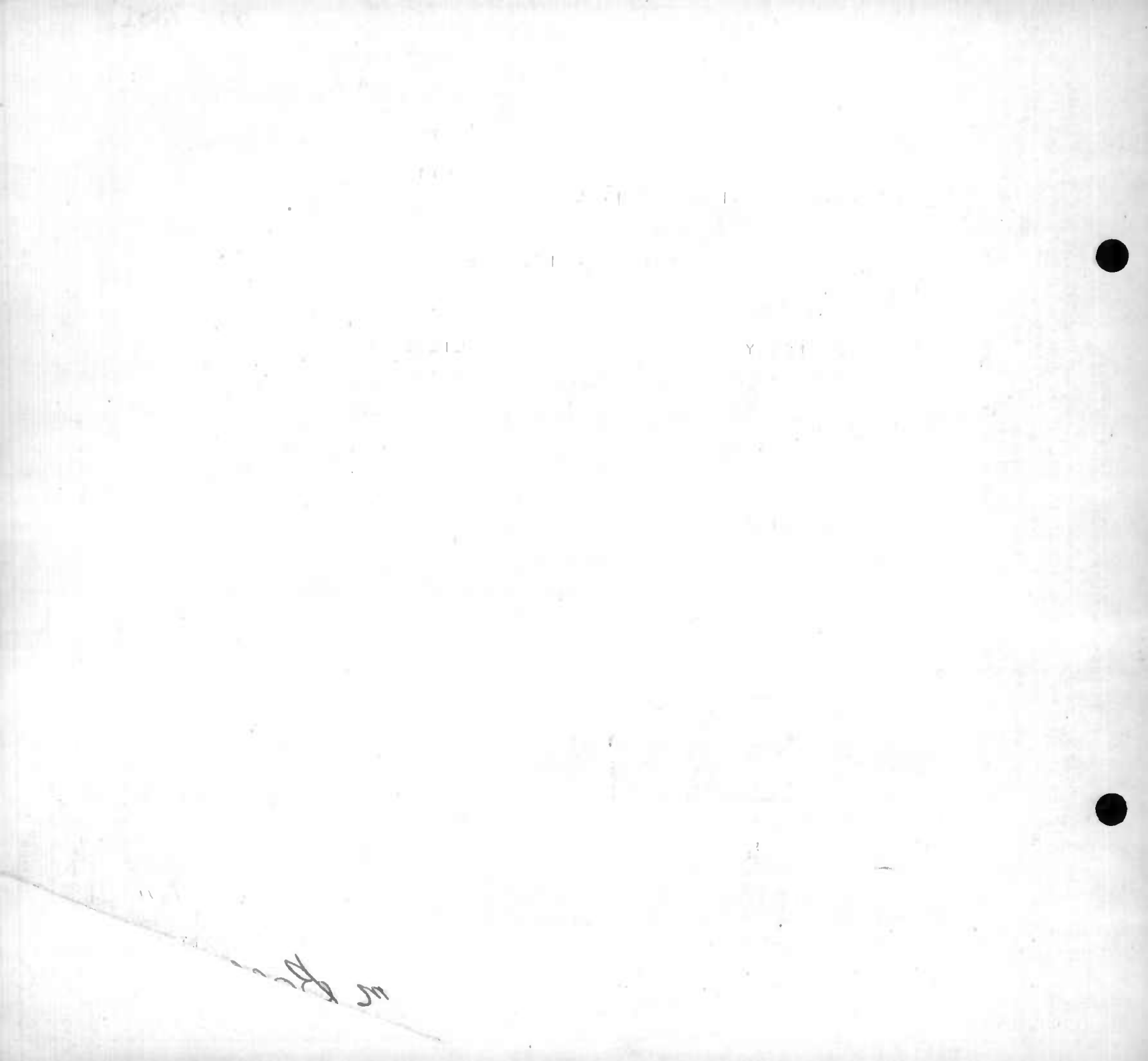
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7380 | |
|--|--|---|--|---|--|
| BIRTH NO. 65 7380 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Miss Mary Tongue | | 2. DATE AND HOUR OF DEATH
July 15, 1965 12:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Union Memorial Hospital
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 12-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | |
| 5. SEX F | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
SINGLE | |
| 8. DATE OF BIRTH
12-10-08 | | 9. AGE (In years last birthday)
56 yrs | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY
Nurse-Hospital | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
James F. Tongue | | 14. MOTHER'S MAIDEN NAME
FRANCES MAGRUDER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-30-0089 | | 17. INFORMANT ADDRESS
Thomas O. Tongue 5212 Tilbury Way | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
330X I | | CAUSE OF DEATH
(A) Rupture of Cerebral Artery
DUE TO
(B) 5-6 hrs.
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21A. DATE OF OPERATION
0 | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 7:30 PM 7/14 1965 to 12:15 AM 7/15 1965 that (we) last saw the deceased alive on 12:15 AM 7/15 1965 and that (our) opinion death occurred on the date and hour and from the causes stated above (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Harry J. Brown | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
HARRY J. BROWN | | 23D. ADDRESS
UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-17-65 | | 24C. NAME of CEMETERY or CREMATORY
Middleham Chapel Churchyard | |
| 24D. LOCATION (City, town, or county) (State)
Lusby Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Jenkins | |
| 25C. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | 25D. ADDRESS
4905 York Rd. Balto. 12, Md. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7381 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7381 | |
|--|---------------------|---|-------------------------------------|---|-----------------------------|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>Elizabeth Disney</i> | | | | 2. DATE AND HOUR OF DEATH
<i>7/11/65 6:00 P M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<i>33 THE JOHNS HOPKINS HOSPITAL</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY <i>27-10</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i>
D. STREET ADDRESS (If rural, give location)
<i>701 RADNOR AVE.</i> | | | |
| 5. SEX
<i>F</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>NEVER MARRIED</i> | 8. DATE OF BIRTH
<i>10-15-12</i> | 9. AGE (In years lost birthday)
<i>53 YRS.</i> | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Demester</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<i>BANKS DISNEY</i> | | 14. MOTHER'S MAIDEN NAME
<i>ELIZABETH Bright-fuel</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. Informant
<i>Hospital Record</i> | | 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>Recurrent Cancer of Colon</i>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>II</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19. INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION
<i>7/11/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Intestinal Obstruction</i> | | 20A. AUTOPSY? (Yes or No)
<i>YES</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/10</i> 19 <i>65</i> to <i>7/11</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4:00 PM</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Ronald Brisman, M.D.</i> | | | | 23B. DATE SIGNED
<i>7/11/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<i>RONALD BRISMAN</i> | | | | 23D. ADDRESS
<i>THE JOHNS HOPKINS HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7-15-65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>Mt Airy Em Balto</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 15 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Raymond Sander</i> | | 25D. ADDRESS
<i>217 E Preston Street</i> | |

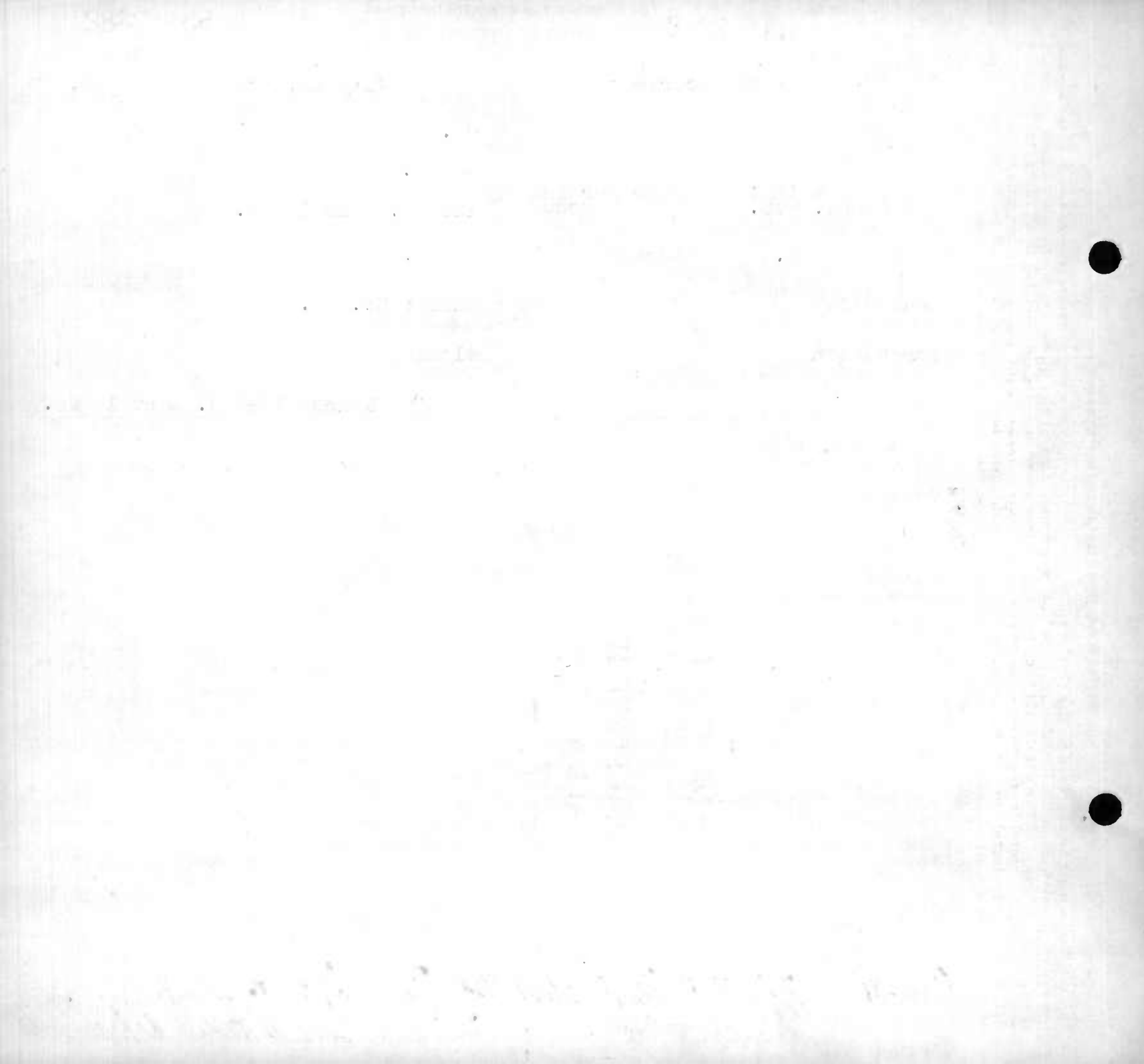


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7382 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7382 | |
|---|------------------------|--|---|--|---|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Mary McCraw | | | | 2. DATE AND HOUR OF DEATH
July 12, 1965 10, PM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

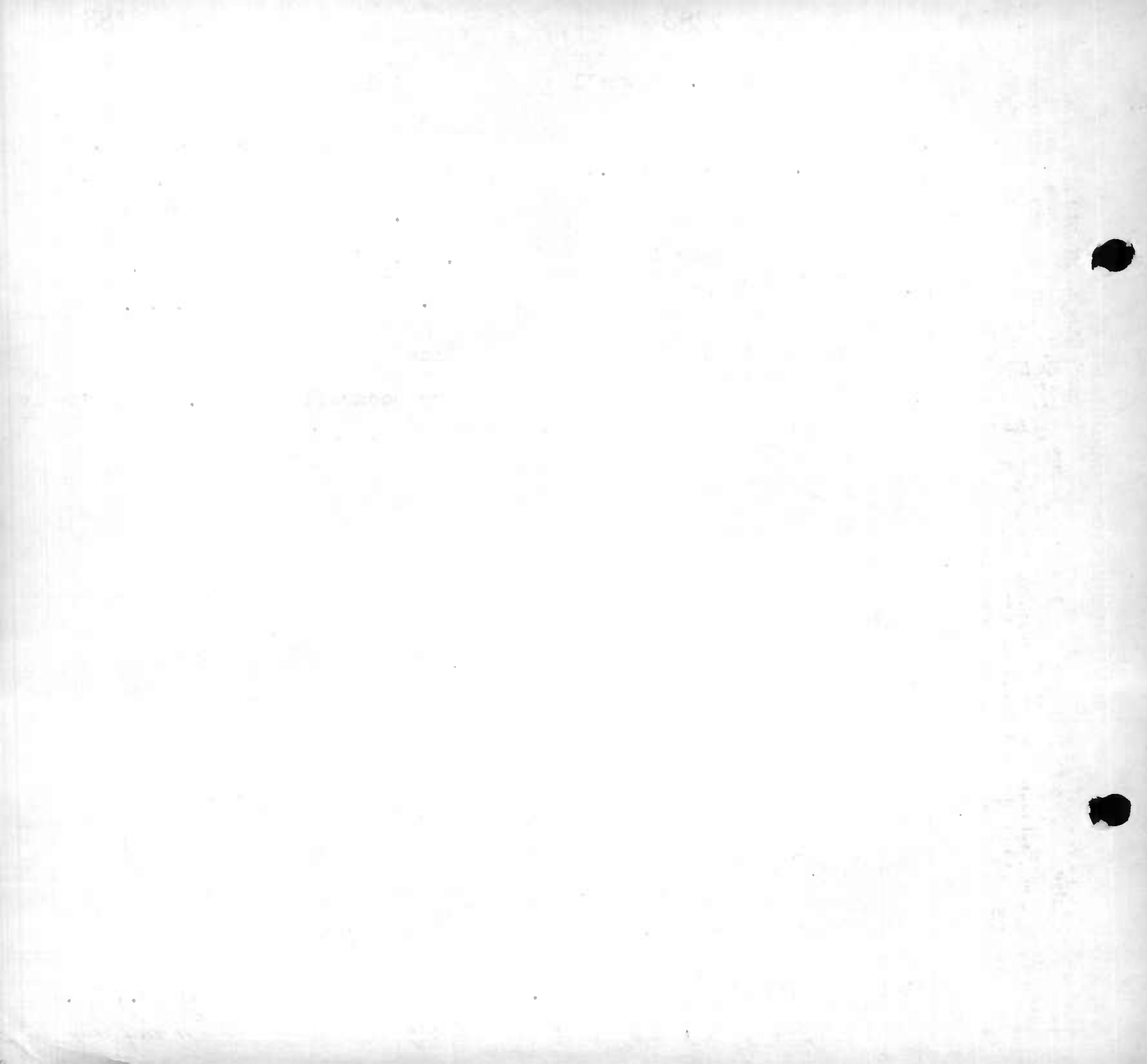
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
George Washington Carver Nursing Home
607 Penna. Ave. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 16-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Balto.
D. STREET ADDRESS (If rural, give location)
1220 W. Lanvale St. | | | |
| 5. SEX
Female | 6. RACE
Col. | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
May 20, 1887 | 9. AGE (In years last birthday)
78 | 11. Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Halifax Co. Va. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
George Moon | | | | 14. MOTHER'S MAIDEN NAME
Delphia ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Alethia Gaines 1220 W. Lanvale St. | | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
(A) Bronchopneumonia
DUE TO
(B) Cor. Arterio-sclerosis
DUE TO
(C) CVA
INTERVAL BETWEEN ONSET AND DEATH
5 days
Unbroken
1 wk | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 25, 1962 to July 12, 1965 , that (I) (we) last saw the deceased alive on July 9, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
E.E. Holt | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
E.E. Holt | | | | 23D. ADDRESS
M.D. 3715 Liberty Hts Ave. | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/15/65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem. | | 24D. LOCATION (City, town or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Williams Funeral Home | | ADDRESS
Schroeder St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7383 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7383 | |
|---|-------------------------|--|--|---|---|---|---|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Roberta L. Cockrell | | | | 2. DATE AND HOUR OF DEATH
July 14, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2533 W. Lafayette Ave. | | | | A. STATE Maryland
B. COUNTY 16-05 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2533 W. Lafayette Ave | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
Married | 8. DATE OF BIRTH
Dec. 10, 80 | | 9. AGE (In years last birthday)
84 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
John Lewis | | | | 14. MOTHER'S MAIDEN NAME
Alice | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Henry Cockrell | | ADDRESS
2533 W. Lafayette Ave. | |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
A Cerebral Vascular accident
A Arterio Sclerosis - Cardio Vascular
DUE TO
(B) DUE TO
(C) DUE TO
INTERVAL BETWEEN ONSET AND DEATH
24 hours
may yes. | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 13 1965 to June 14 1965, that (I) (we) last saw the deceased alive on June 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Joseph H. Zierler M.D. | | | | 23B. DATE SIGNED
7/15/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dos. H. Zierler | | | | 23D. ADDRESS
2502 Eutaw Place Balt - 17 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/18/65 | | 24C. NAME of CEMETERY or CREMATORY
Church Cem. | | 24D. LOCATION (City, town, or county) (State)
Northumberland Co., Va. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Feltner | | 25C. FUNERAL DIRECTOR
George L. Kula 1348 N. Calhoun St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7384 | |
|--|---------|--|------------------|--|--|
| BIRTH NO.
65 7384 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Bessie Beane Towels | | July 14, 1965 9:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland | | 16-02 | |
| 39 Provident Hospital, Inc.
1514 Division Street | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 1313 W. Lanvale Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | Negro | Separated | 8/6/03 | 61 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | | | Virginia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Freddie Beane | | Maggie Fauteroy | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 558-14-7207 | | Jessie Gross 101 Cumberland St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) UREMIA | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/7/1965 to 7/14/1965, that (I) (we) last saw the deceased alive on July 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. Marie Rigaud | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. Marie Rigaud | | 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 7-18-65 | | Church Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR | | 24F. ADDRESS | |
| Harrischester Co., VA. | | George A. Kilar | | 1348 N. Calhoun St. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| JUL 15 1965 | | Robert E. Jackson | | George A. Kilar | |

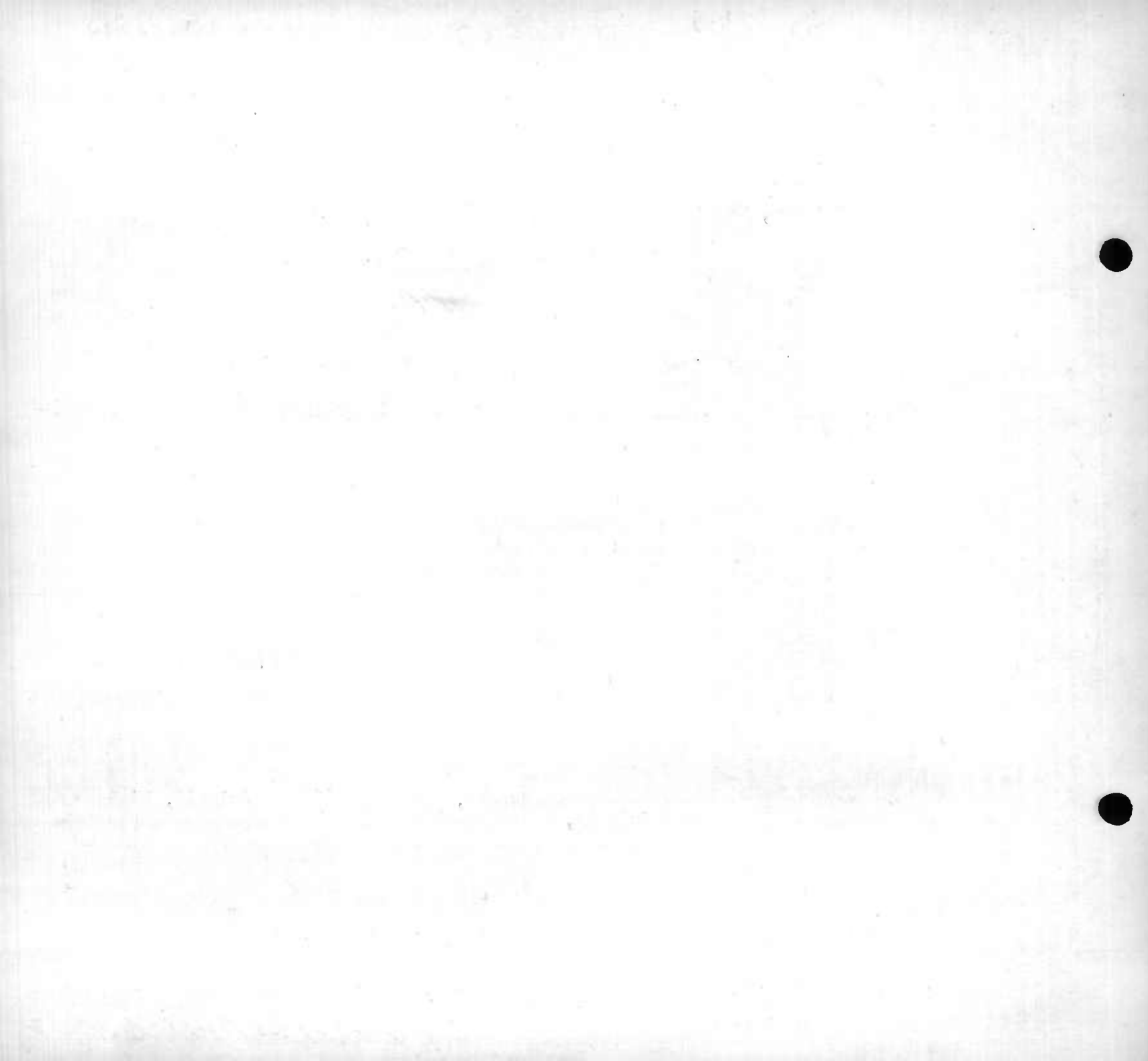
10/4/65 - (unseen)

Hypertension - 2nd. and 3rd. stage
Elder from Providence felt in
new phase - (unseen) felt in

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

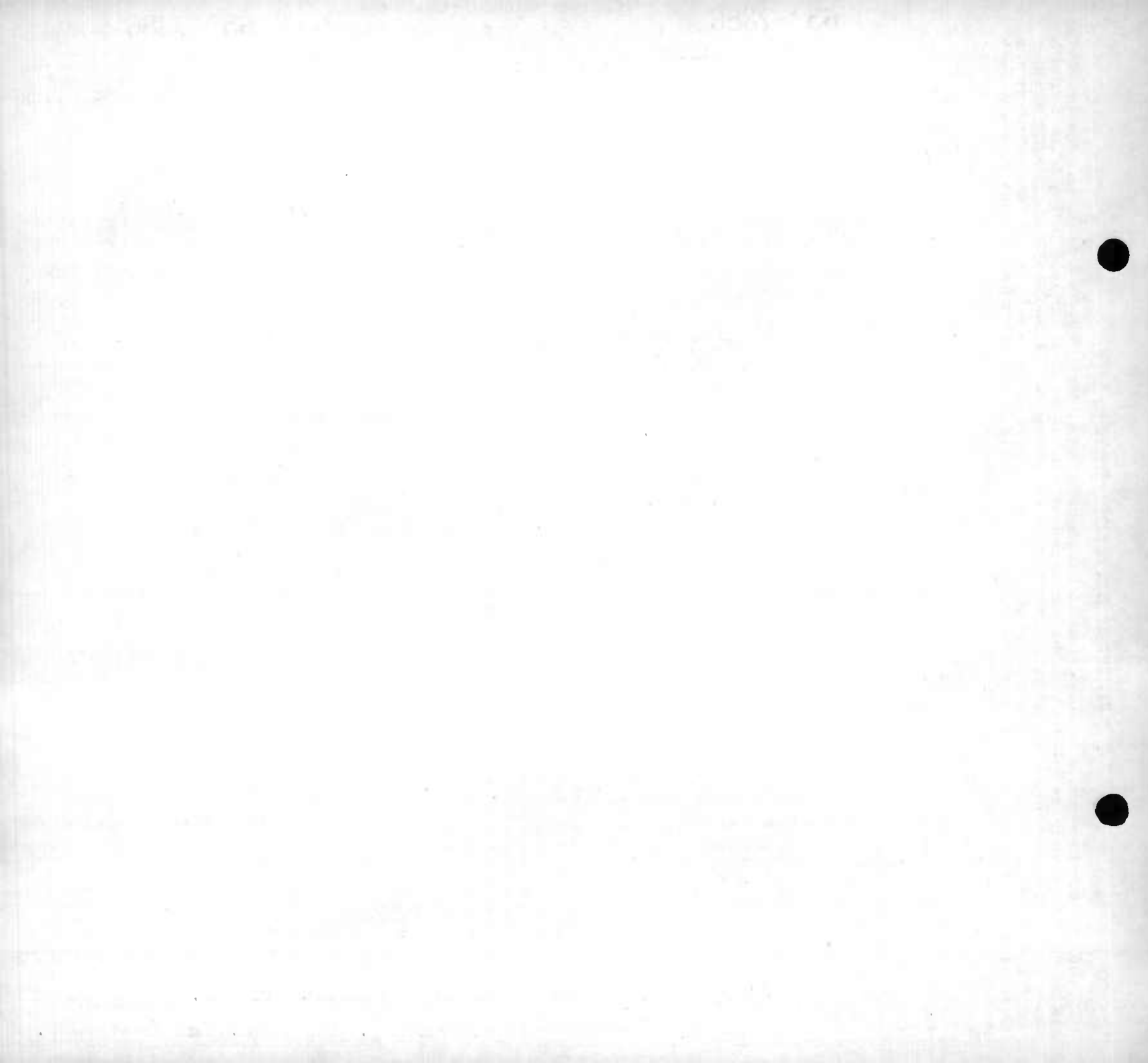
| BIRTH NO. 65 7385 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7385 | |
|--|-------------------------|---|--|--|------------------------------|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Elise Bryant | | | |
| 2. DATE AND HOUR OF DEATH
7-12-65 12:15 AM | | | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | | A. STATE Maryland
B. COUNTY 13-04 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | D. STREET ADDRESS (If rural, give location)
2330 Bryant Avenue | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
July 27, 15 | 9. AGE (In years lost birthday)
49 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country)
VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Portus Warren | | | | 14. MOTHER'S MAIDEN NAME
Mildas Jones | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Levin Bryant 2330 Maple St | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
331X I | | | | CAUSE OF DEATH
(A) DUE TO
CVA
(B) DUE TO
Arteriosclerosis
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
6/5/65
Unknown | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 5, 1965 to July 12, 1965 , that (I) (we) last saw the deceased alive on July 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Alvin Thompson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/12/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Alvin Thompson | | | | 23D. ADDRESS
1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-16-65 | | 24C. NAME OF CEMETERY OR CREMATORY
Mt Calvary Cem. | | 24D. LOCATION (City, town, or county) (State)
Anne Arundel Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
George A. Lila 1348 N. Calhoun St | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

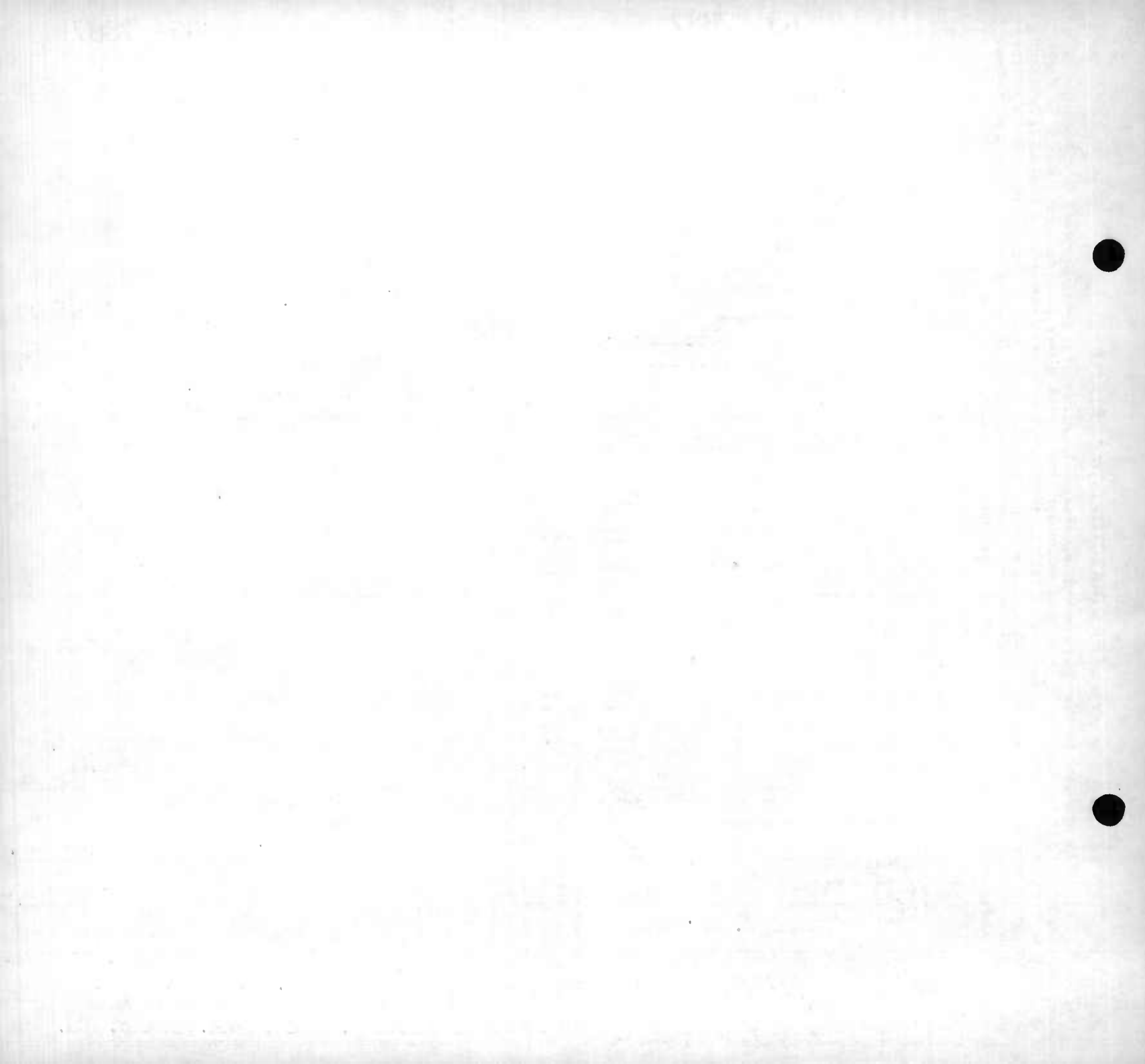
| | | | | | |
|---|-----------|--|--------------------------|--|--|
| BIRTH NO. 65 7386 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7386 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Agnes ADA HUFFMAN | | 2. DATE AND HOUR OF DEATH JULY 15, 1965 12:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND 26-03
B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSP. | | D. STREET ADDRESS (If rural, give location) 3543 PELHAM AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 3/31/09 | 9. AGE (In years lost birthday) 56 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE WORK | | 10B. KIND OF BUSINESS OR INDUSTRY Not Known | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME EDWARD Dougherty | | 14. MOTHER'S MAIDEN NAME FLORENCE HAWKINS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Not Known | | 16. SOCIAL SECURITY NO. 219-05-7072 | | 17. INFORMANT ADDRESS PAUL HUFFMAN - SAME AS DECEASED | |
| 18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebral Thrombosis, left and right middle cerebral arteries? (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 13 months and 9 months respectively. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from NOV. 10 1964 to July 15 1965, that (I) (we) last saw the deceased alive on July 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Reuben C. Guerrero M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/15/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) REUBEN C. GUERRERO | | 23D. ADDRESS Montebello State Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. STATE (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 15 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|---|---|--|---|--|--|--|--|
| 65 7387 | | | | | Registered No. 65 7387 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) EDITH E. TOLSON | | | 2. DATE AND HOUR OF DEATH
JULY 15, 1965 5:15 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
MONTEBELLO STATE HOSP. | | | | | A. STATE
MARYLAND | | | | |
| (If not in hospital or institution, give street address or location) | | | | | B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
3007 SOUTHERN AVE | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH
Feb. 16, 1893 | 9. AGE (In years last birthday)
72 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN J. Tolson | | | | 14. MOTHER'S MAIDEN NAME
PAULINE WELLS | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
not known | | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT ADDRESS
MRS. CEIL TOLSON 173 Dumbarton Rd | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
153.8 I Melanotic Adenocarcinoma | | | | CAUSE OF DEATH
(A) DUE TO
Primary - colon | | | | INTERVAL BETWEEN ONSET AND DEATH
+ 2 yrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| (C) _____ | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No)
NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 16 1965 to July 15 1965 , that (I) (we) last saw the deceased alive on July 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
Reuben C. Guerrero | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
REUBEN C. GUERRERO | | | | | | 23D. ADDRESS
Montebello State Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/16/65 | | 24C. NAME of CEMETERY or CREMATORY
Woodlawn Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Balto., Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 15 1965 | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | | 25C. FUNERAL DIRECTOR ADDRESS
Leonard J. Rubk, Inc., Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

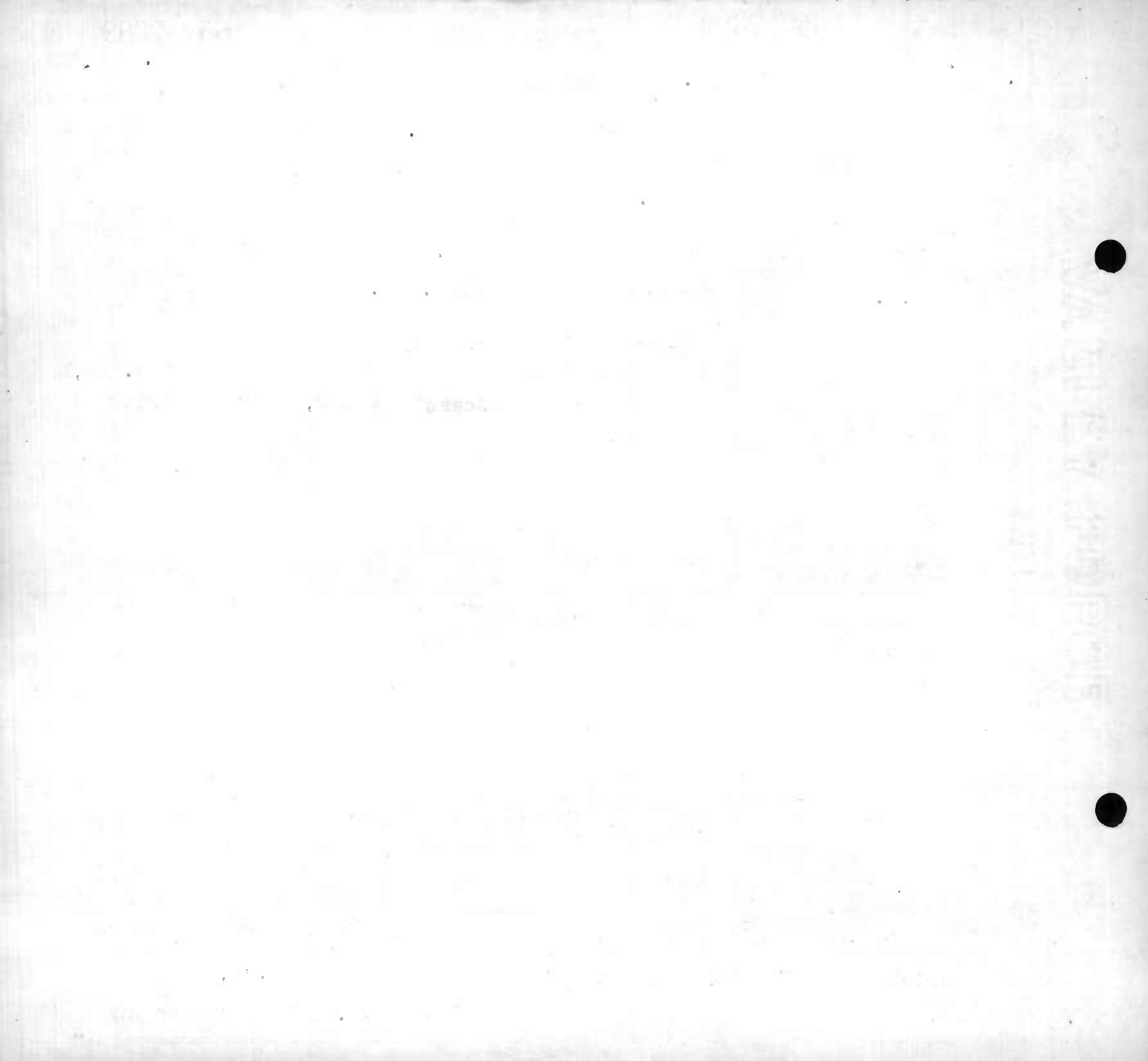
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7388 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7388 | |
|---|--|--|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED Sadie F. Husselbaugh
(Type or Print) <i>Mrs. Sadie Husselbaugh</i> | | | | 2. DATE AND HOUR OF DEATH 7/14/65 7:30 pm M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Lafayette Hospital
46 | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 5. SEX F. | | | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | |
| 8. DATE OF BIRTH Feb. 11/85 | | | | 9. AGE (in years lost birthday) 80 | | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bookkeeper | | | | 10B. KIND OF BUSINESS OR INDUSTRY
Md. Casualty Co. | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 13. FATHER'S NAME
John Husselbaugh | | | | 14. MOTHER'S MAIDEN NAME
Katie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
216 09 8126 | | 17. INFORMANT
Ted Husselbaugh, 5904 Franklin Ave | |
| 18. 239X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cardiac failure
caused obstruction of
subt. tract tract
Tumor abdomen | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 14 19 65 to he death 19 65 , that (I) (we) last saw the deceased alive on July 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Kurt Levy | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
KURT LEVY | | | | 23D. ADDRESS
3103 N. Charles Street 18 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/17/65 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park | | 24D. LOCATION (City, town, or county) (State)
Balto. 29, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR
Witzke F.D. | | ADDRESS
4101 Edmondson Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

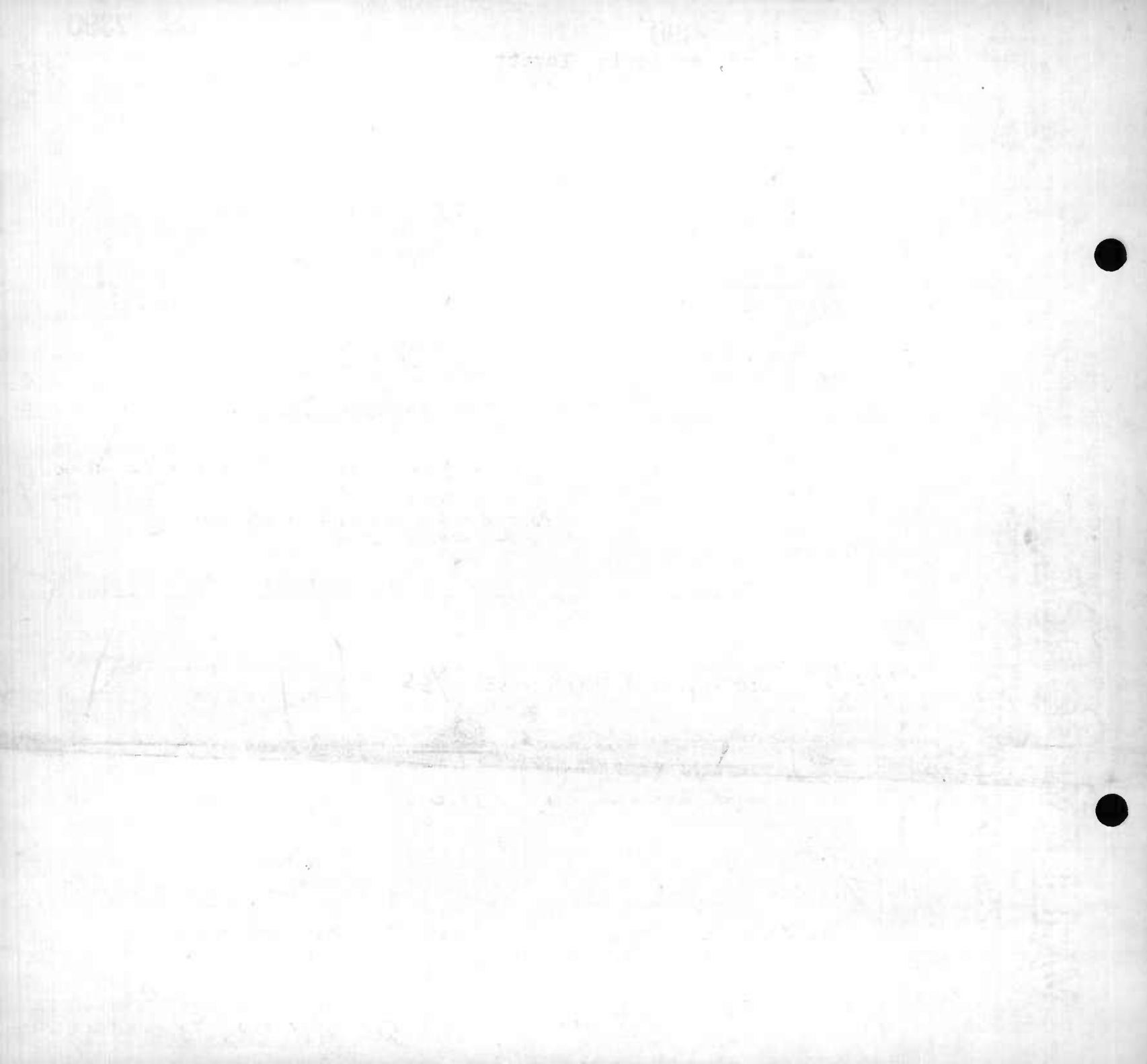
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7389 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 65 7389 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Caroline E. Walter | | 2. DATE AND HOUR OF DEATH
July 13/65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Hoods Nursing Home
90 5313 Edmondson Ave. | | A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
Hoods Nursing Home | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
Sept. 24/81 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
H.W. | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Renoff | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Balton, M
Jesse Spector, 5400 Frederick Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Colitis Ulcerative | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
8 years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Osteoarthritis, Atherosclerosis, Diabetes | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 15 19 65 to July 13 19 65 , that (I) (we) last saw the deceased alive on June 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
John F. Schaefer | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
July 15 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
JOHN F. SCHAEFER | | 23D. ADDRESS
401 Randory Rd. Balto. Md. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
Loudon Park | |
| 24D. LOCATION (City, town, or county) (State)
Balto. 29, Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fadden | | 25C. FUNERAL DIRECTOR ADDRESS
Witzke F.D. 4101 Edmondson Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7390 | |
|---|------------------|---|--|---|---|
| BIRTH NO. 65 7390 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED Ireland, Benjamin Lovett | | 2. DATE AND HOUR OF DEATH JULY 15, 1965 5:20 A.M. EDT | |
| (Type or Print) IRELAND, BENJAMIN LOVETT | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL | | | A. STATE MARYLAND
B. COUNTY 28-04 | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 29 | | |
| | | | D. STREET ADDRESS (If rural, give location)
73 UPMANOR RD. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH 5/6/12 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLAIMS ADJUSTER | | 10B. KIND OF BUSINESS OR INDUSTRY
INSURANCE | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
THOMAS WILLIAM IRELAND | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
217-26-1626 | | 17. INFORMANT
Evelyn Ireland, 73 Upmanor Rd |
| 18. 193.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
INTRACEREBRAL HEMORRHAGE | | | INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hours | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) POST-OP GLIOBLASTOMA MULTIFORME
DUE TO FRONTAL LOBE | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) _____ | | |
| 19A. DATE OF OPERATION
3/7/12/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
GLIOBLASTOMA @ FRONTAL LOBE | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10/65 19 to 7/15 1965, that (I) (we) last saw the deceased alive on 7/15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Ronald L. Paul | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/15/65 |
| 23C. PHYSICIAN'S NAME (Type)
RONALD L. PAUL | | | 23D. ADDRESS
UNIVERSITY HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/17/65 | | 24C. NAME OF CEMETERY or CREMATORY
Lorraine | |
| 24D. LOCATION
Dr. Boes, 7. Md. | | 24E. NAME OF REGISTRAR
Robert E. Fawcett | | 24F. FUNERAL DIRECTOR
Witke F.H. 4101 Edmondson Ave | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|------------------------------|--|--|
| BIRTH NO. 65 7391 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7391 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Hemstreet, Howard | | 2. DATE AND HOUR OF DEATH
7/14/65 12:35 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
NEW YORK V-29 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
SCHUYLERVILLE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
Johns Hopkins Hospital 33 | | D. STREET ADDRESS (If rural, give location)
59 CHURCH ST. | | | |
| 5. SEX
MALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
10-12-98 | 9. AGE (In years lost birthday)
66 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SELF EMPLOYED | | 10B. KIND OF BUSINESS OR INDUSTRY
RETIRED | | 11. BIRTHPLACE (State or foreign country)
SCHUYLERVILLE, N.Y. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
CHARLES HEMSTREET | | 14. MOTHER'S MAIDEN NAME
EMMA DUMAS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
128-18-8269 | | 17. INFORMANT
MARGARET MAYBER 1403 SHORE RD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
410X I
Rheumatic Heart Disease | | CAUSE OF DEATH
(A) DUE TO
Mitral Stenosis & Insufficiency
(B) DUE TO
Arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION
7/14/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Mitral Stenosis & Insufficiency | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 14/1965 to 7/14/1965, that (I) (we) last saw the deceased alive on July 14/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H.R. Gertner, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/14/65 | |
| 23C. PHYSICIAN'S NAME (Type)
H.R. GERTNER, JR. | | 23D. ADDRESS
THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
JULY 19, 1965 | | 24C. NAME OF CEMETERY OR CREMATORY
PROSPECT HILL | |
| 24D. LOCATION (City, town, or county) (State)
SCHUYLERVILLE NEW YORK | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | |
| 25C. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road #36 | | 25D. ADDRESS | | | |

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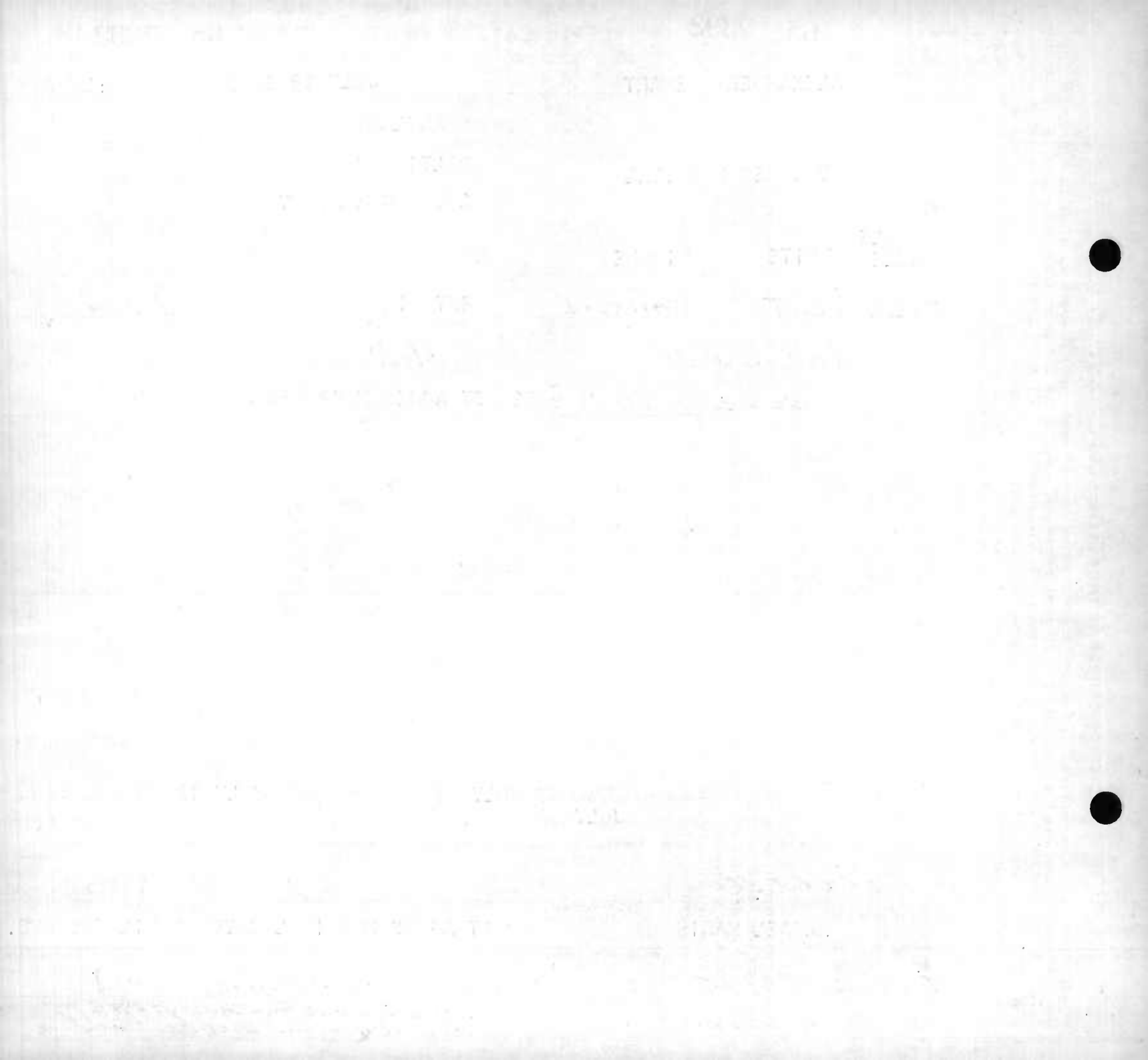
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7392 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7392 | |
|---|----------------------|--|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) ALEXANDER EWART | | | 2. DATE AND HOUR OF DEATH
JULY 13 1965 9:20 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

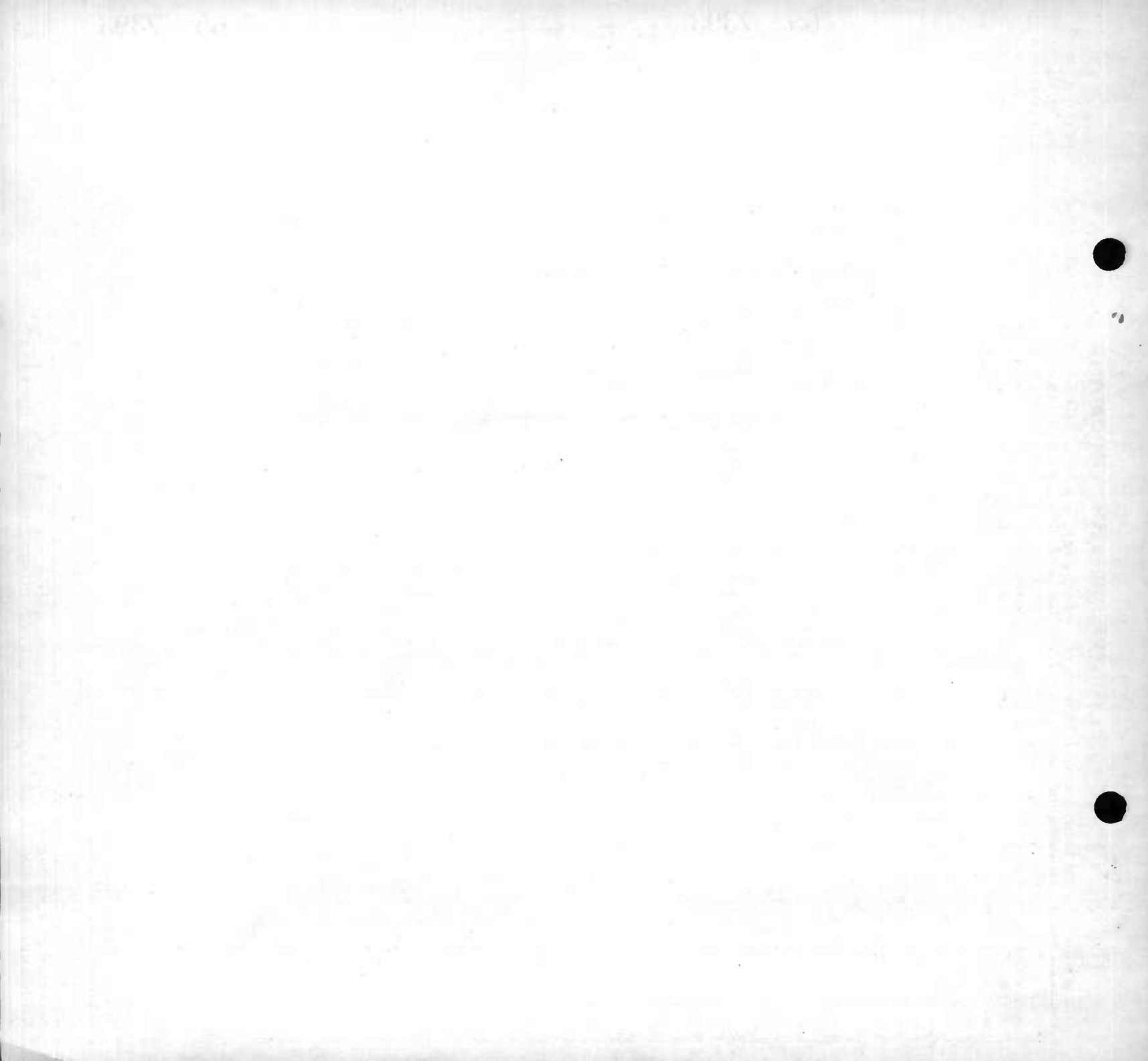
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 70-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
2015 MCHENRY ST | | |
| 5. SEX MALE
AMKR | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
Nov. 2, 1887 | 9. AGE (In years last birthday)
77 | If Under 1 Yr. Months: Ooys: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MACHINIST | | 10B. KIND OF BUSINESS OR INDUSTRY
RAILROAD | | 11. BIRTHPLACE (State or foreign country)
ESTONIA | |
| 13. FATHER'S NAME
Unknown | | | 14. MOTHER'S MAIDEN NAME
Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
705 03 9552 | | 17. INFORMANT
ST AGNES HOSP RECORDS | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH
Acute Myocardial Infarction -
Severe coronary thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 11 19 65 to JULY 13 19 65 , that (I) (we) last saw the deceased alive on JULY 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Rafael Marin | | | M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7 14 65 |
| 23C. PHYSICIAN'S NAME (Type)
RAFAEL MARIN | | | 23D. ADDRESS
M.D. ST AGNES HOSPITAL CATON & WILKENS AVE. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7-17-65 | | 24C. NAME of CEMETERY or CREMATORY
NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
650-L. Schwab Funeral Home
Francis W. Geller 2101 Broadway Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7393 | |
|--|--------------|--|----------------------------|--|---|
| BIRTH NO. 65 7393 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Anne Smith | | 2. DATE AND HOUR OF DEATH 7-14-65 7:45P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland B. COUNTY 19-51 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Box-Wil-Ba Convalescent Home | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 1713 W. Franklin St. | |
| 5. SEX F. | 6. RACE Col. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 6-21-1897 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Odenton MD | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME RICHARD CARTER | | 14. MOTHER'S MAIDEN NAME FANNIE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address 13 N. Fulton Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Hypertensive arteriosclerotic C.V.D. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-18-1961 to 7-14-1965, that (I) (we) last saw the deceased alive on 7-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C.R. Campbell | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 7-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) C.R. Campbell | | 23D. ADDRESS M.D. 1618 W. North Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-19-1965 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. LOCATION (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber M.D. | | 25C. FUNERAL DIRECTOR Marshall P. Hayes 3806 Green St | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7394 | |
|---|-------------------------|---|--|--|--|
| BIRTH NO. 65 7394 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) SNADER, MINNIE F. | | | | 2. DATE AND HOUR OF DEATH
7-13-65 1:00A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
40 ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HOWARD CO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
ELLCOTT CITY 63-00
D. STREET ADDRESS (If rural, give location)
221 FOXHILL DRIVE | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
7-14-75 | 9. AGE (In years lost birthday)
89 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
SILAS BISH | | | 14. MOTHER'S MAIDEN NAME
MARIE A. CROWL | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT ADDRESS
ST. AGNES RECORDS-CATON & WILKENS AVES |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
422.1 I Cardio-vascular accident
INTERVAL BETWEEN ONSET AND DEATH
3 weeks.
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 7 1965 to JULY 13 19 65 , that (I) (we) last saw the deceased alive on JULY 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Carl H. Matthey | | | | 23B. DATE SIGNED
7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type)
CARL H. MATTHEY | | | | 23D. ADDRESS
M.D. ST. AGNES HOSPITAL -CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
burial | | 24B. DATE
7-16-65 | | 24C. NAME OF CEMETERY or CREMATORY
Krider Cem. | |
| 24D. LOCATION (City, town, or county) (State)
Westminster, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
E. Fisher, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
E. C. Higinbotham Ellicott City, Md. | |

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FUNERAL DIRECTOR: IMPORTANT

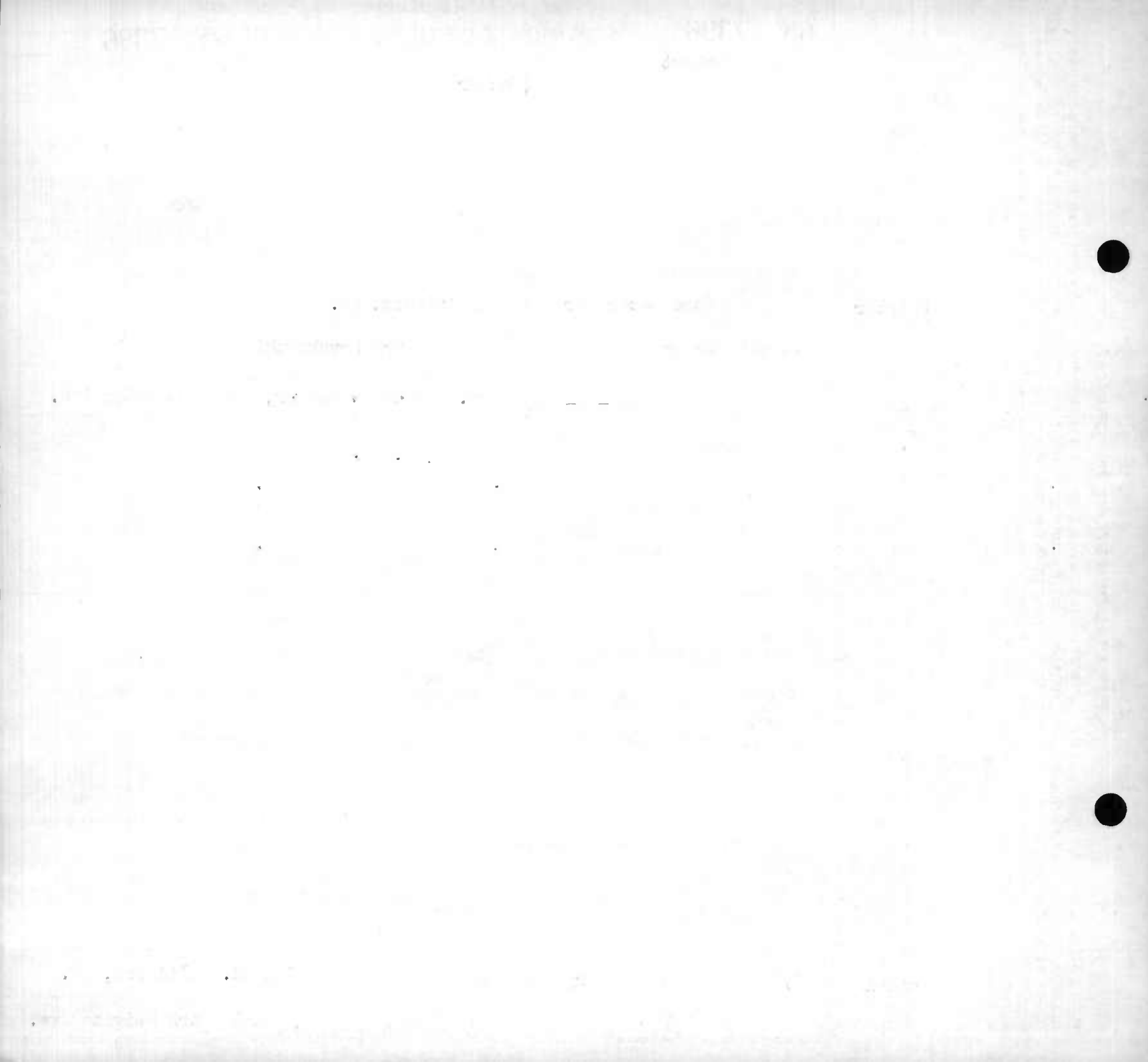
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7395 | |
|--|--------------|---|-----------------------------------|---|---|
| BIRTH NO. 65 7395 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MINNIE SCHWARZMAN | | 2. DATE AND HOUR OF DEATH
JULY 13, 1965 11:30 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
90 Asburton House Inc. | | A. STATE Maryland
B. COUNTY 15-11 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location)
Same as # 3 3520 N. Hilton Rd. | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
S | 8. DATE OF BIRTH
SEPT. 7, 1891 | 9. AGE (In years last birthday)
73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
John Schwarzmman | | 14. MOTHER'S MAIDEN NAME
Anna Backman | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NO | | 17. INFORMANT ADDRESS
Mary Fuchs 2843 Pelham Rd. Balto. | |
| 18. I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic heart disease | | (A) DUE TO | | 4 years | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from July 28, 1961 to July 13, 1965
that (I) (we) lost saw the deceased alive on July 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Abraham B. Hurwitz | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
July 13, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
ABRAHAM B. HURWITZ | | 23D. ADDRESS
M.D. 7501 LIBERTY ROAD BALTIMORE MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
R. E. Farber | |
| 25C. FUNERAL DIRECTOR
John T. Stansbury 6411 Windsor Mill | | ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7396 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7396 | |
|---|-----------|--|--------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Robert Sylvester Kocher (Kocher) | | | | 2. DATE AND HOUR OF DEATH 9:10 PM 17 July 1965 9:10 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore 42 | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland U.S.A. 27-18 | | B. COUNTY | |
| | | | | C. CITY OR TOWN Baltimore | | (If outside city limits, write RURAL and give township) | |
| | | | | D. STREET ADDRESS 3720 Manchester Ave | | (If rural, give location) | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 4/14/15 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10B. KIND OF BUSINESS OR INDUSTRY Home Decorator | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Joseph Kocher | | | | 14. MOTHER'S MAIDEN NAME Mary Novakowski | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-12-0213 | | 17. INFORMANT ADDRESS Mrs. Nancy L. Kocher, 3720 Manchester Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Ventricular Fibrillation DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 30 min. | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Acute Coronary Occlusion DUE TO | | 72 hr. | |
| | | | | (C) Arteriosclerotic Cardiovascular Disease | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Spontaneous Pneumothorax | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 7/11 1965 to 7/14 1965, that (I) last saw the deceased alive on 7/14 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Solomon Robbins | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) Solomon Robbins | | | | 23D. ADDRESS M.D. Sinai Hospital, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State) German Hill Rd. Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Solomon Robbins | | ADDRESS 4611 Park Heights Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

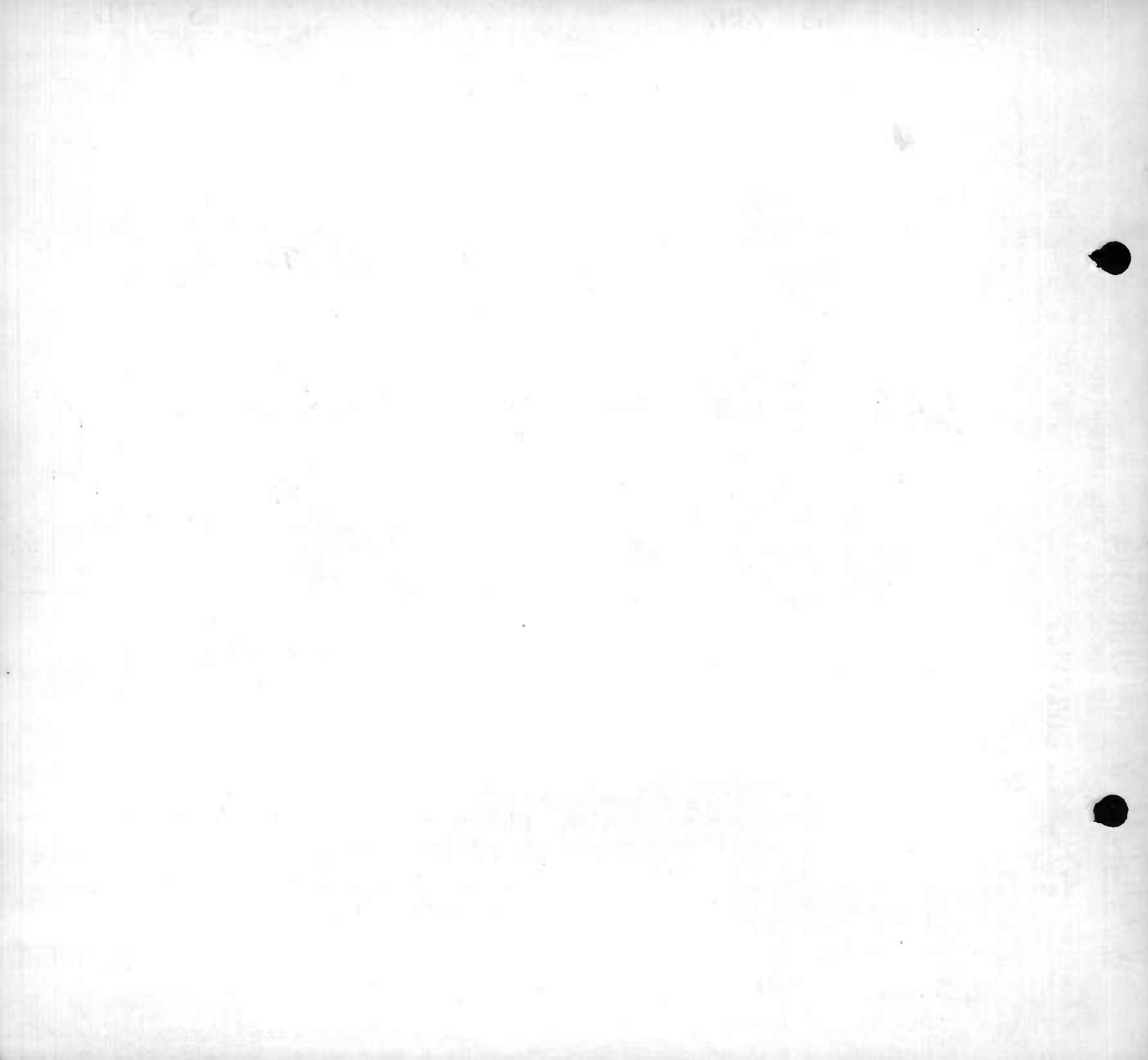
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7397 | |
|--|--|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO.
 M.E. CASE NO.
 1. NAME OF DECEASED
 (Type or Print) WILLIAM R. DAVIS </div> <div> 2. DATE AND HOUR OF DEATH
 JULY 14, 1965 1:25 P. M. </div> </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

<div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION
 36 FRANKLIN SQUARE HOSPITAL </div> <div> (If not in hospital or institution, give street address or location) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
<div style="display: flex; justify-content: space-between;"> <div> A. STATE
 MARYLAND </div> <div> B. COUNTY
 21-02 </div> </div> | | |
| 5. SEX
M | | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOWER |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PAPER HANGER | | 10B. KIND OF BUSINESS OR INDUSTRY
PAPER HANGER | | 8. DATE OF BIRTH
1-10-'93 | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD | | | 9. AGE (In years last birthday)
72 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
JACOB DAVIS | | | 14. MOTHER'S MAIDEN NAME
ANNA GAGES | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES | | | 16. SOCIAL SECURITY NO.
W. W. I 217-05-9599 | | 17. INFORMANT ADDRESS
James M. Davis 603 Allen St - (25) |
| 18. CAUSE OF DEATH
<div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) DUE TO
 hepatic coma

 (B) DUE TO
 liver cirrhosis

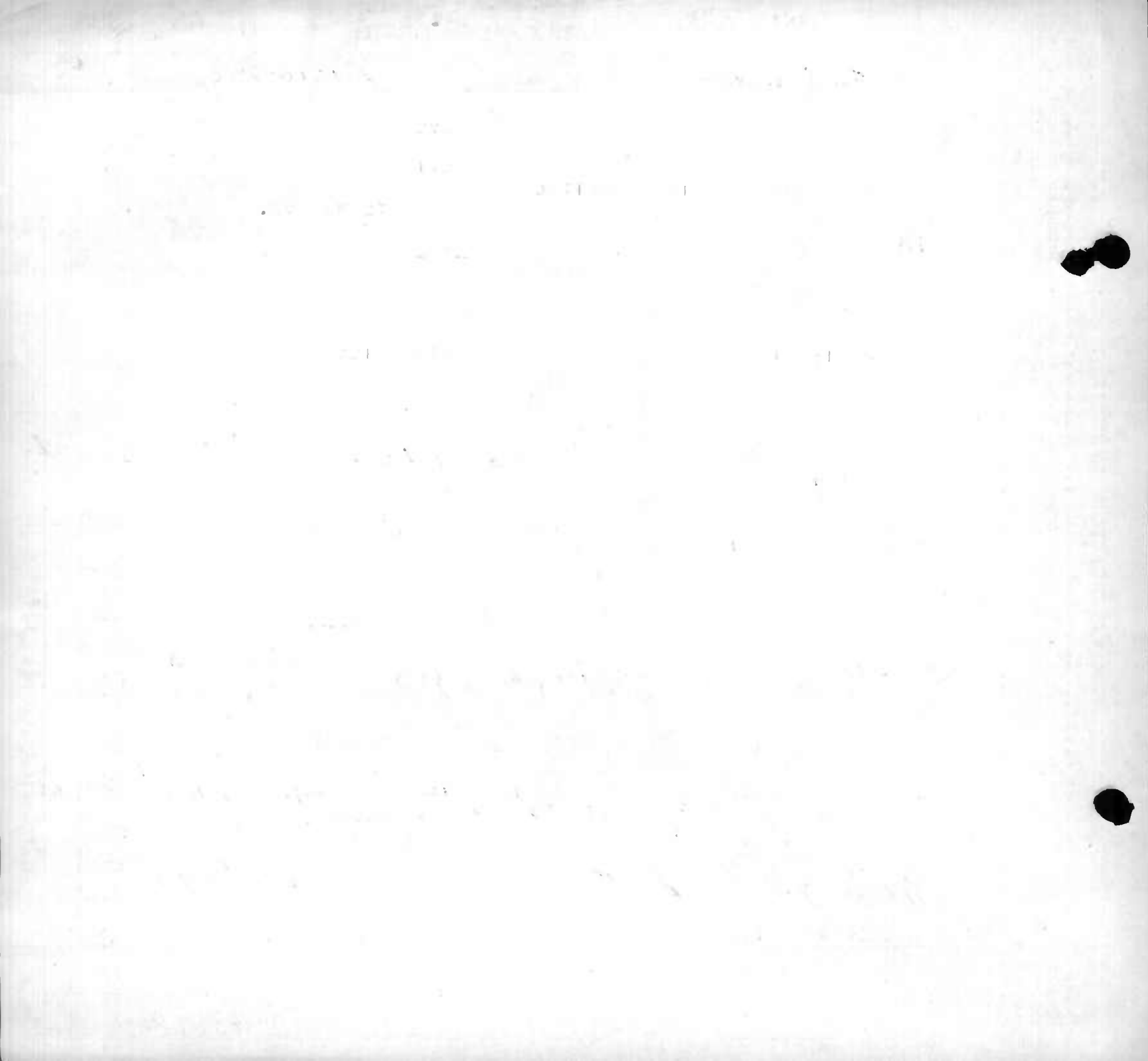
 (C) </div> </div> | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/6/65</u> 19 to <u>7/14/65</u> 19, that (I) (we) last saw the deceased alive on <u>July 14</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James V. del Pilar | | | | 23B. DATE SIGNED
7/14/65 | |
| 23C. PHYSICIAN'S NAME (Type)
JAIME V. DEL PILAR | | 23D. ADDRESS
FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/19/65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION
Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
John J. Cowan & Son, Inc. 901 Hollins St Baltimore (23) | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 65 7398 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7398 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Earl Dixon</i> | | 2. DATE AND HOUR OF DEATH
<i>7-13/65 9:50pm</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MARYLAND</i>
B. COUNTY <i>7-04</i> | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>33 THE JOHNS HOPKINS HOSPITAL</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i> | | D. STREET ADDRESS (If rural, give location)
<i>1039 RUTLAND AVE.</i> | |
| 5. SEX
<i>M</i> | 6. RACE
<i>C</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>SEPERATED</i> | 8. DATE OF BIRTH
<i>2-16-20</i> | 9. AGE (In years last birthday)
<i>45</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Painter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>SELF-EMPY.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>BENJAMIN DIXON</i> | | 14. MOTHER'S MAIDEN NAME
<i>BERTHA HILL</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>YES</i> | | 16. SOCIAL SECURITY NO.
<i>219-01-2517</i> | | 17. INFORMANT ADDRESS
<i>CARL DIXON 1045 N. BROADWAY</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
<i>Ca of Lung</i> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 months</i> | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Cerebral metastasis</i> | | | |
| 19A. DATE OF OPERATION
<i>3 7-12</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>removal of lung Ca</i> | | 20A. AUTOPSY? (Yes or No)
<i>YES</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>July 12 1965</i> to <i>July 13 1965</i> , that (I) (we) last saw the deceased alive on <i>July 13 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
<i>Walter Southwick</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<i>7-13</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>WALTER SOUTHWICK</i> | | M.D. 23D. ADDRESS
<i>JOHNS HOPKINS HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>7-17-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>MT CALVARY</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>a.a. COUNTY Md</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 16 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farkner</i> | |
| 25C. FUNERAL DIRECTOR ADDRESS
<i>JOSEPH-KNIGHT 1639 N. BROADWAY</i> | | | | | |

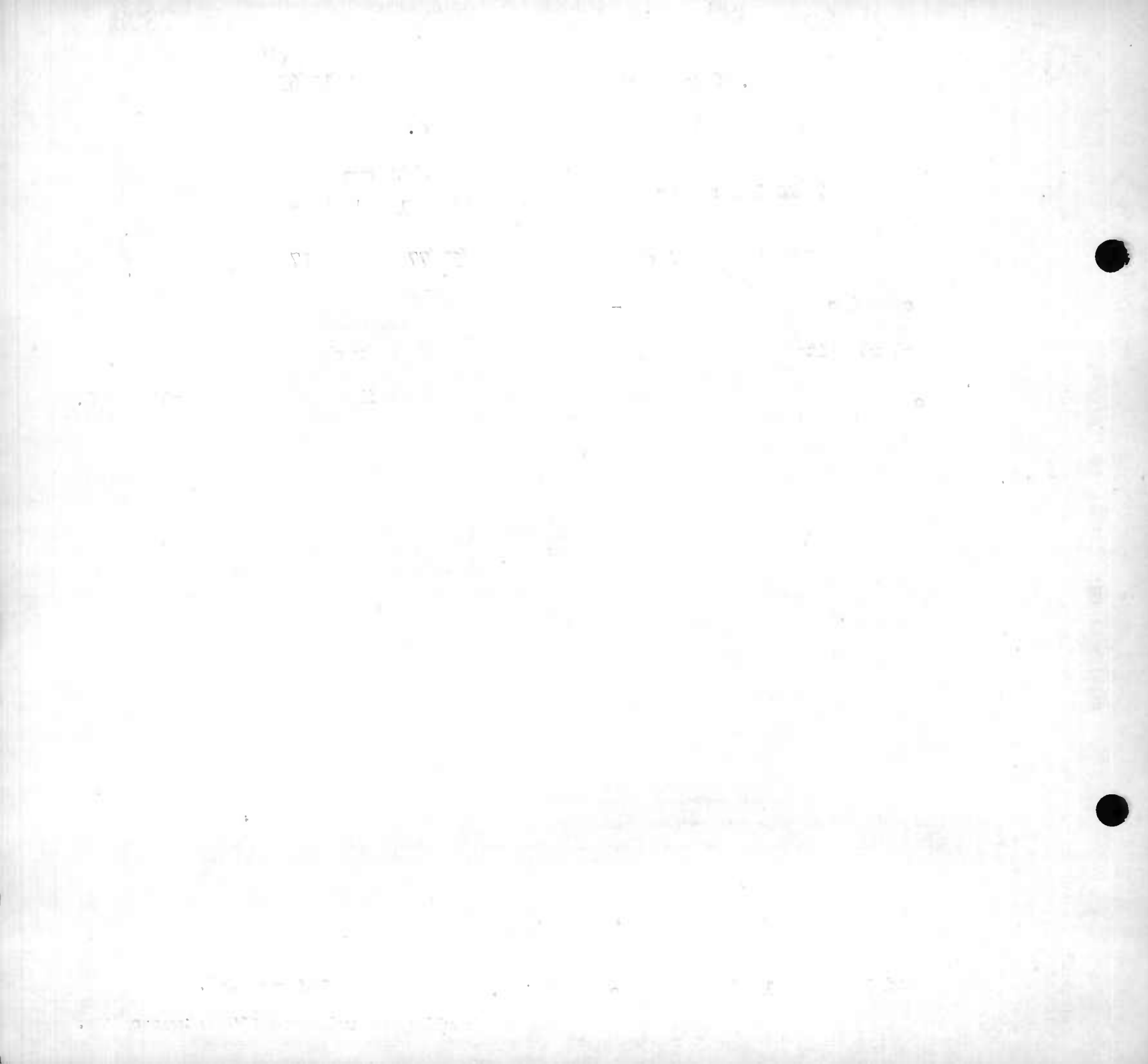


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|--|------------------|---|---|--|---|---|--|--|------------------------------|----------------------------------|--|
| BIRTH NO. 65 7399 | | | | | Registered No. 65 7399 | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Emma B. Clarke | | | | | 2. DATE AND HOUR OF DEATH
7/13/65 1 5 15 P.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3600 Clarks Lane | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md. B. COUNTY 27-20
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3600 Clark's Lane | | | | | | |
| 5. SEX
F | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widow | 8. DATE OF BIRTH
8/31/77 | 9. AGE (In years last birthday)
87 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME
Robert White | | | | | 14. MOTHER'S MAIDEN NAME
Emma Brook | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family | | ADDRESS
Potomac, Md. | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
422.1 I
Myocarditis & Congestive Heart Failure due to Arterio Sclerosis Cardiovascular Disease
Antecedent Causes
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Anxiety | | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 12 1965 to July 13 1965, that (I) (we) lost saw the deceased alive on July 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Paul Beverly M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED
7/14/65 | | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Paul Beverly M.D. | | | | | 23D. ADDRESS
5420 York Rd - Baltimore Md | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/17/65 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cem. | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | | 25B. NAME OF REGISTRAR
Robert E. Talbot | | | 25C. FUNERAL DIRECTOR
McCully Funeral Home | | | ADDRESS
237 Patapsco Ave. | | |



63-34925
65 7400

BALTIMORE CITY HEALTH DEPARTMENT

65 7400

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS

MOORE

2. DATE AND HOUR PRONOUNCED DEAD

July 5, 1965

2:15 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Hampstead

D. STREET ADDRESS (If rural, give location)

RFD #1

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Dec. 21, 1963

9. AGE (In years
last birthday)

1

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Dorothy Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dorothy Murray, Hampstead, Md.

18. E 833.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Traumatic Injuries.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Driveway

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

RFD #1, Hampstead, Md.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
7 5 '65 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell out of and run over by drifting
car.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/6/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-8-1965

23C. NAME of CEMETERY or CREMATORY

Hampstead

23D. LOCATION

(City, town, or county)

Hampstead

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 16 1965

24B. NAME OF REGISTRAR

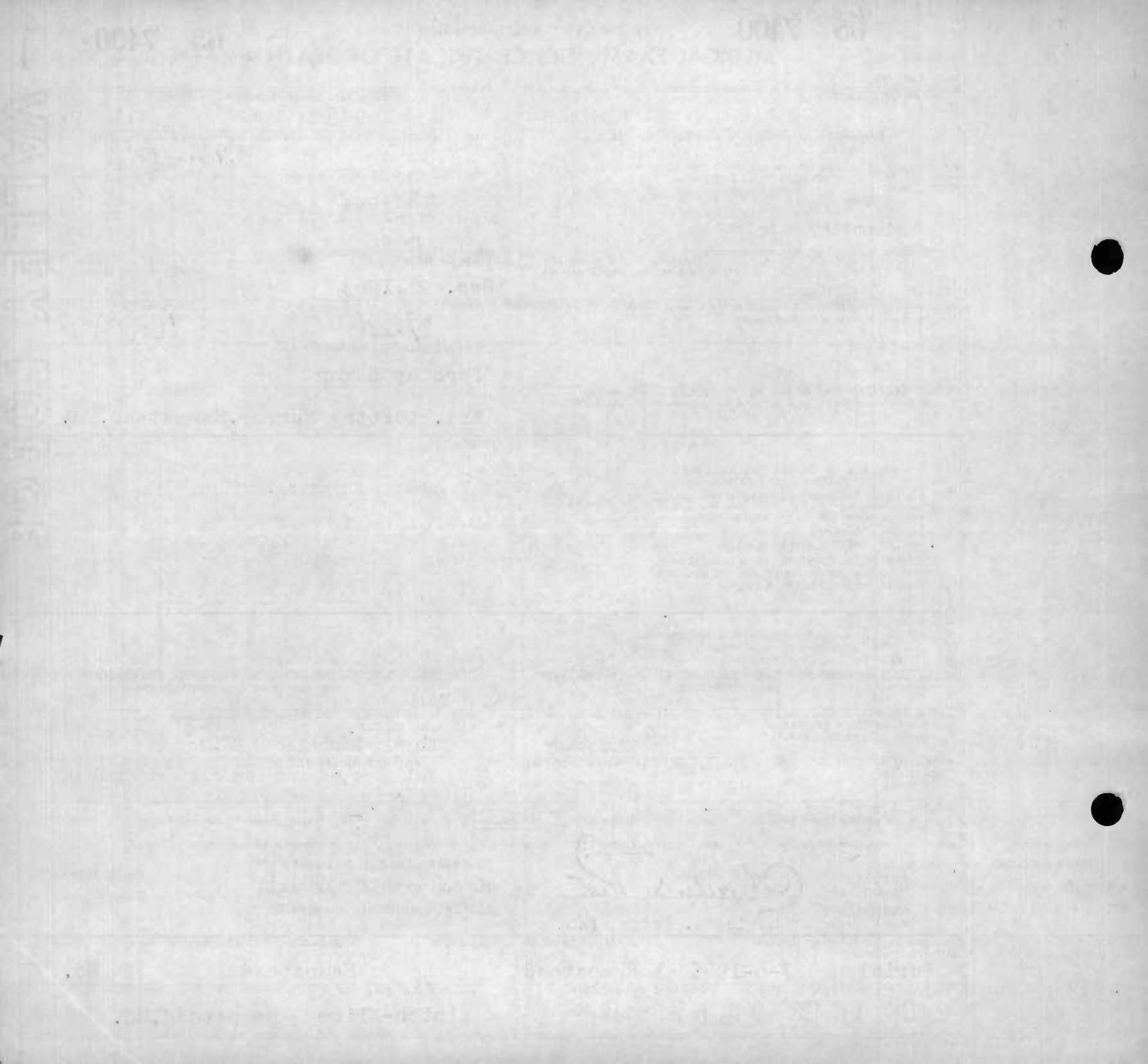
Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

Tipton-Eline

ADDRESS

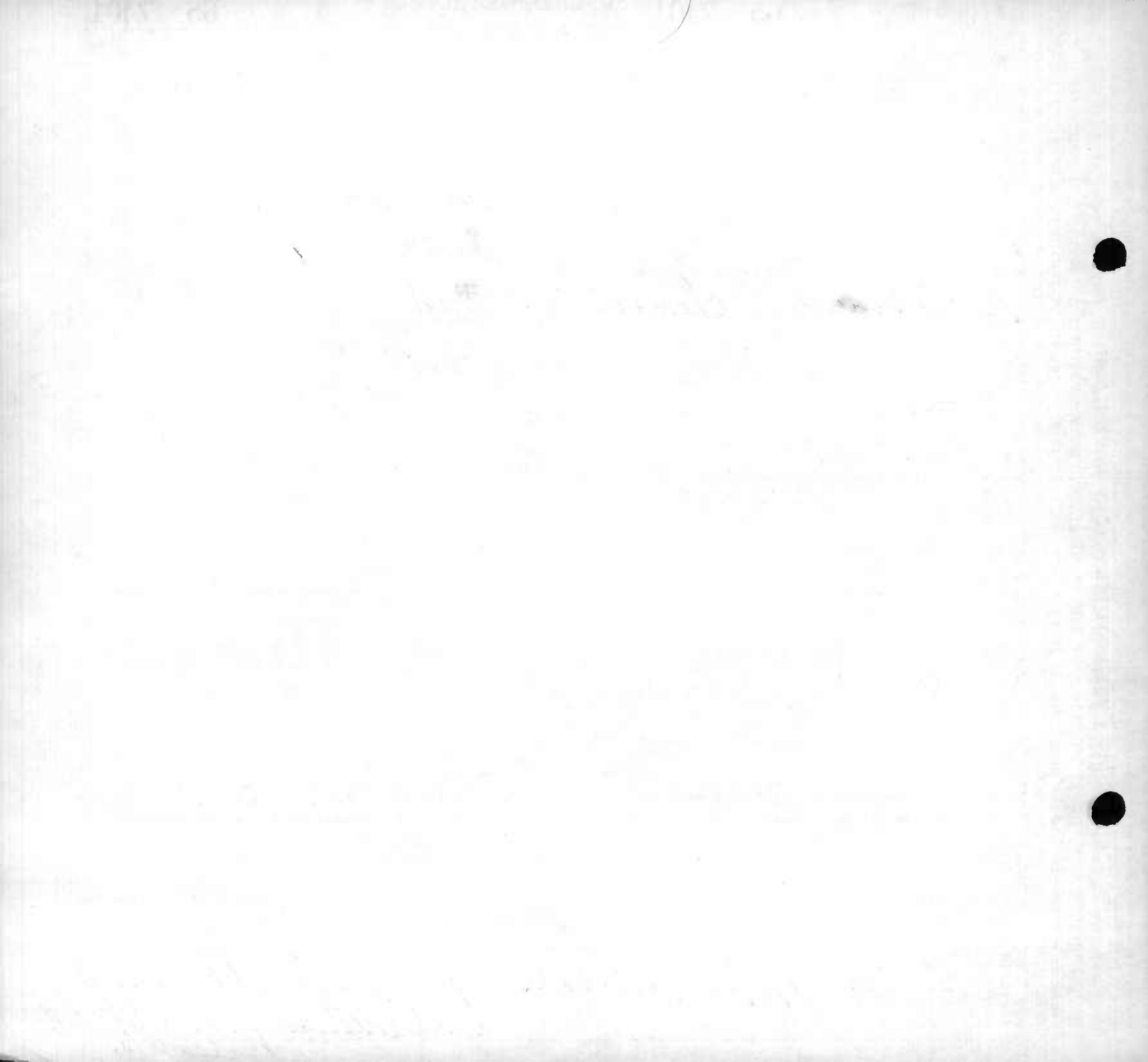
Hampstead, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | | | |
|--|--|--|--|--|--|--|--|---|--|----------------------------|--|
| 65 7401 | | | | 65 7401 | | | | 65 7401 | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | Wilson, Clarence | | | | 5:45 AM 7/14/65 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | M. | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | | | B. COUNTY | | | |
| 38 University Hosp | | | | Md | | | | 13-02 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | | | | | |
| Baltimore | | | | 2323 Eutaw pl. | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | |
| M | | C | | Wid | | Nov. 23, 1893 | | 71 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Laborer | | | | Chemical Co. | | | | Ind. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| John Wilson | | | | Louise Vand | | | | USA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| no | | | | 218-05-080 | | | | Estelle Francis 2102 Pooder St | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Branchogenic Case | | | | 2-65-7-65 | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | | | |
| II | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| D | | | | NO | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/12/65 19 to 7/14/65 19, that (I) (we) last saw the deceased alive on 7/14/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | | |
| Philip P. Toske | | | | | | | | 7/14/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | |
| Philip P. Toske | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | 7/17/65 | | Mt. Calvary | | Annapolis Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| JUL 16 1965 | | | | Robert E. Farkes | | | | Wm. L. Whitman Jr. 1701 Mt. Calvary Rd. Baltimore Md. | | | |

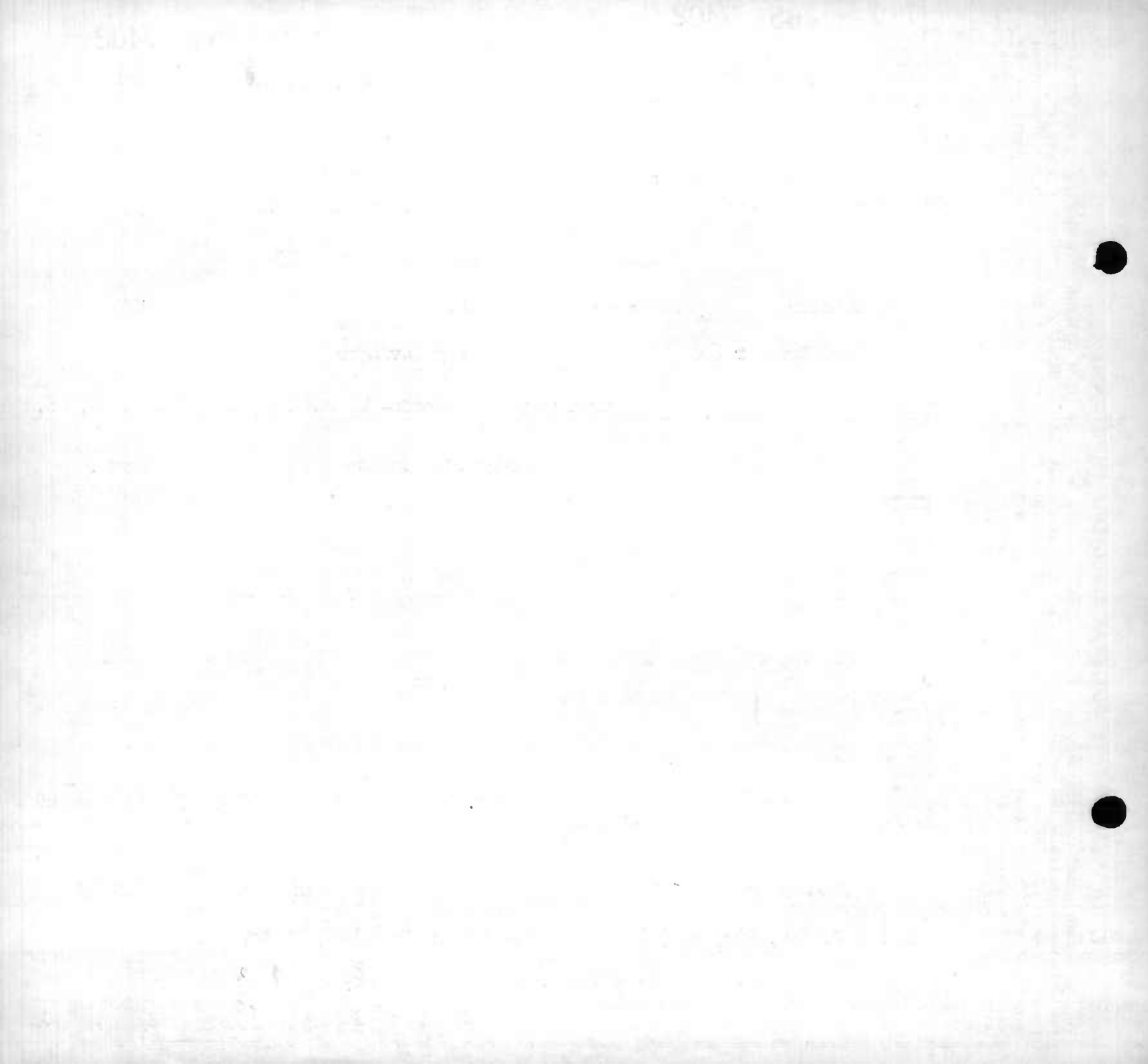


FUNERAL DIRECTOR: IMPORTANT

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RGB

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7402 | |
|---|---|---|---|---|---------------------------------------|
| BIRTH NO. 65 7402 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) JAMES TERRANCE CROPPER | | 2. DATE AND HOUR OF DEATH
July 13, 1965 2:15 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| 57 FULL NAME OF HOSPITAL OR INSTITUTION
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | A. STATE Pa.
B. COUNTY V-35 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Lenni Mills | | | |
| | | D. STREET ADDRESS (If rural, give location)
429 Station Lane | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
12/28/41 | 9. AGE (In years last birthday)
23 | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Quartermaster | | 10B. KIND OF BUSINESS OR INDUSTRY
Seafarer | | 11. BIRTHPLACE (State or foreign country)
Pa. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Robert Cropper SR. | | 14. MOTHER'S MAIDEN NAME
Amy Favinger | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)
None | | 16. SOCIAL SECURITY NO.
194-32-4572 | | 17. INFORMANT ADDRESS
Records- US PHS Hospital, Balto, 11, Md. | |
| 18. 201X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Hodgkin's disease | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr. 19 65 to July 13 65 , that (I) (we) last saw the deceased alive on July 13 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE
Thomas J. Lau M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
7/13/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Thomas J. Lau, Surgeon (R) | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7/17/65 | | 24C. NAME OF CEMETERY or CREMATORY
CALVARY CEM. | |
| 24D. LOCATION (City, town, or county) (State)
GLEN RIDDLE PA. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fellers | | 25C. FUNERAL DIRECTOR ADDRESS
Griffith Funeral Chapel
E. S. Mac Nabb, Catonsville Md | |



1
F-240

BALTIMORE CITY HEALTH DEPARTMENT

65 7403

BIRTH NO. 65 7403 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JAMES C. FOGLE Sr. 2. DATE AND HOUR PRONOUNCED DEAD July 14, 1965 11:12 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1323 Spring Avenue

5. SEX Male 6. RACE Caucasian 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed 8. DATE OF BIRTH Jan 18, 1890 9. AGE (In years last birthday) 75 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer 11. BIRTH PLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 218-10-1886 17. INFORMANT Melva A. Winkelman 1261 Neighbors Ave

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Crushed Chest. DUE TO (B) DUE TO (C) DUE TO

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Front of 1323 Spring Avenue

21D. TIME OF INJURY (APPROX.) 7 14 '65 A 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR? Working under trunk which fell off jack.

22. I certify that I held an Inquiry Inspection and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 7/14/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE July 17, 1965 23C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. JUL 16 1965 24B. NAME OF REGISTRAR Robert E. Fairbank 24C. FUNERAL DIRECTOR Ruly F. Cook 1211 Chesaco Ave. ADDRESS

VS 151-REV. 1/1/65

Jan 18 1880 75

Washington

428

History of the

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818-10-1880 Jan 18 1880 75

History of the

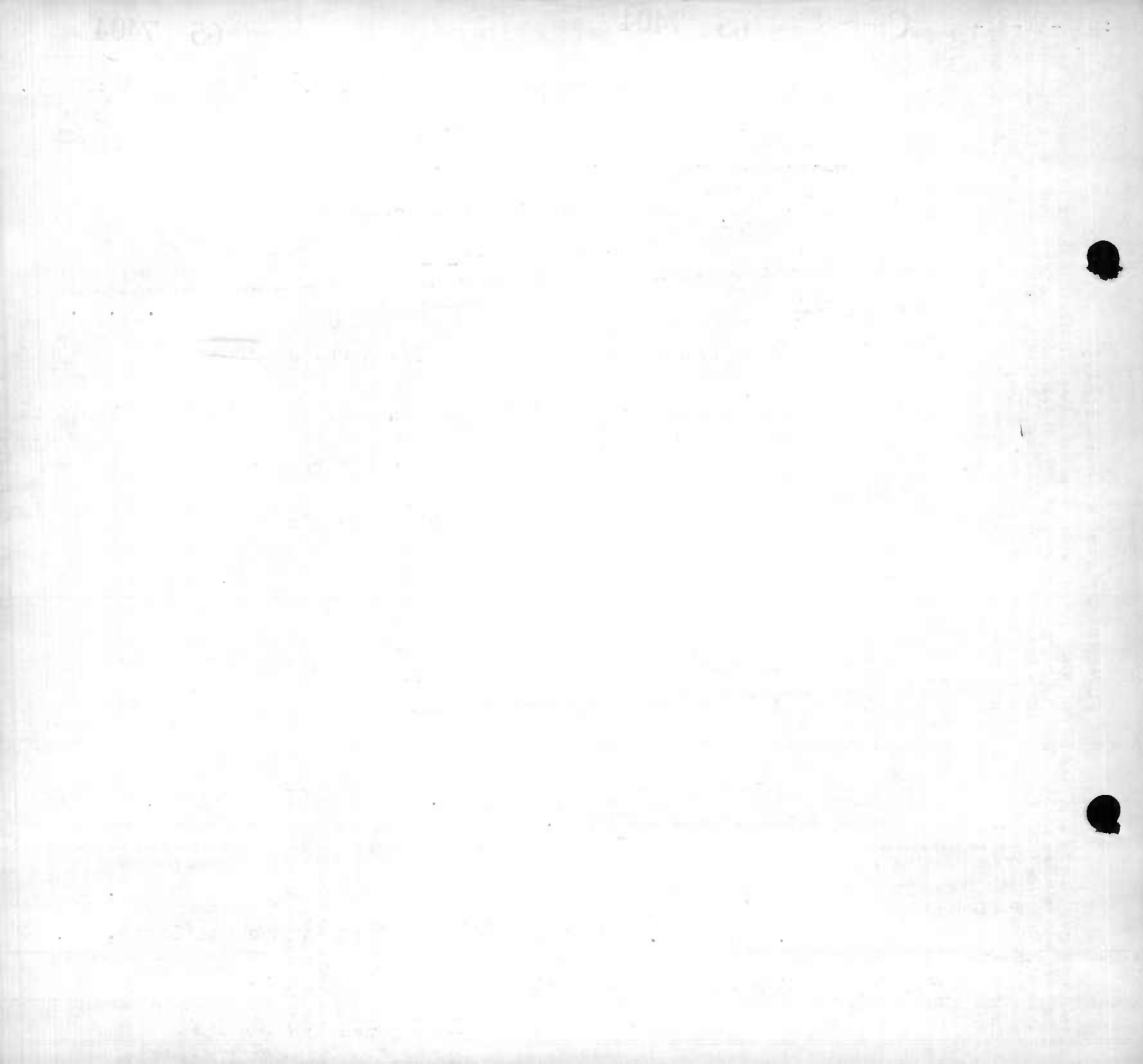
History of the
History of the
History of the

LS: 37-31-31-

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. <u>65 7404</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65 7404</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>Edward Cunningham</u> | | 2. DATE AND HOUR OF DEATH
<u>JULY 8, 1965</u> <u>10:00 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>26-36</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>31</u>
<u>Baltimore City Hospitals</u>
<u>4940 Eastern Avenue</u>
<u>Baltimore, Maryland #21224</u> | | D. STREET ADDRESS (If rural, give location)
<u>6400 Gary Avenue</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>11-5-91</u> | 9. AGE (In years lost birthday)
<u>73</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CARPENTER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | 13. FATHER'S NAME
<u>John ?</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-18-1210</u> | | 17. INFORMANT ADDRESS
<u>RECORDS: BCH: 4940 Eastern Avenue #24</u> | |
| 18. <u>420.1 I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) <u>Myocardial Infarction</u>
DUE TO
(B) <u>Arteriosclerosis</u>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>II</u>
<u>Emphysema</u> | | 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No)
<u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1965</u> to <u>July 8, 1965</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>H. Rathbun</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>July 8, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Howard K. Rathbun</u> | | 23D. ADDRESS
<u>4940 Eastern Avenue Baltimore, Md. #24</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>7/12/65</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Louisa Park Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>BALTO. MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 16 1965</u> | | 25B. NAME OF REGISTRAR
<u>R. E. Fothergill</u> | |
| 25C. FUNERAL DIRECTOR
<u>G. TRUMAN Schaub</u> | | ADDRESS
<u>8542 Froedrick Ave. (29)</u> | | | |



BIRTH NO. 65 7405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7405

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARY TALBERT 2. DATE AND HOUR PRONOUNCED DEAD July 12, 1965 10:38 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2630 Francis Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

9-20-1923

9. AGE (in years last birthday)

42

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Isiah Ligon

14. MOTHER'S MAIDEN NAME

Sarah Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

—

17. INFORMANT

John Talbot 2630 Francis St.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) —
DUE TO(C) —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/14/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

7-16-65

23C. NAME OF CEMETERY or CREMATORY

Balto. National

23D. LOCATION (City, town, or county) (State)

Baltomd

24A. DATE REC'D BY HEALTH DEPT.

JUL 16 1965

24B. NAME OF REGISTRAR

R. E. Farley, M.D.

24C. FUNERAL DIRECTOR

Purnell S. Oden Balto. Md.

ADDRESS

VALLEY FORT

FUNERAL DIRECTOR: IMPORTANT

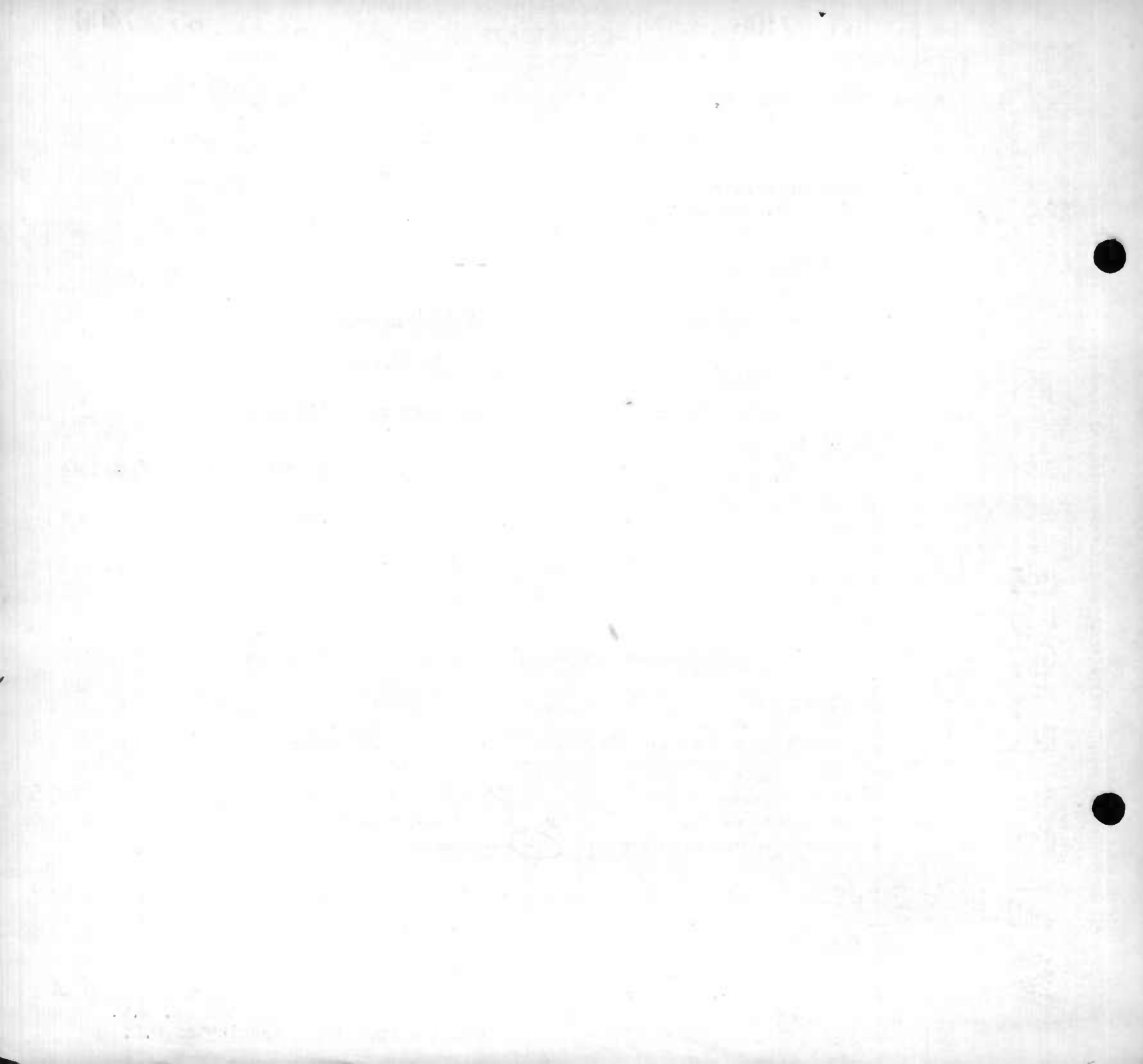
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|---------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7406 | |
| BIRTH NO. 65 7406 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH
JULY 12, 1965 8:00 P.M. | |
| 1. NAME OF DECEASED
(Type or Print) Elijah Jenkins | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY USA | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Lutheran Hosital
Baltimore, Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
713 Wicklow Road | |
| 5. SEX
Male | 6. RACE
Colored | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
2-2-84 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday)
81 |
| 13. FATHER'S NAME
Cesier Jenkins | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 14. MOTHER'S MAIDEN NAME
Susie Wilson | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Emaly Anderson 713 Wicklow Road | |
| 18. 352X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) CEREBRAL THROMBOSIS
DUE TO
(B) GENERALIZED ATHEROSCLEROSIS
DUE TO
(C) SENILITY | |
| INTERVAL BETWEEN ONSET AND DEATH
7 WEEK

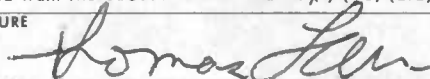
16 YEARS. | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
INANITION | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A | |
| 21F. HOW DID INJURY OCCUR? N/A | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB 25, 1964 to JULY 8, 1965 , that (I) (we) last saw the deceased alive on JULY 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Frederick A. Peck | | 23B. DATE SIGNED
July 13, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Frederick A. Peck | | 23D. ADDRESS
1506 N. Potomac St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
July 13, 65 | |
| 24C. NAME OF CEMETERY or CREMATORY
HARMONY CEMETERY | | 24D. LOCATION (City, town, or county) (State)
WASHINGTON D.C. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR
William Spangler | | 25D. ADDRESS
524 8th St. N.E.
Washington D.C. | |

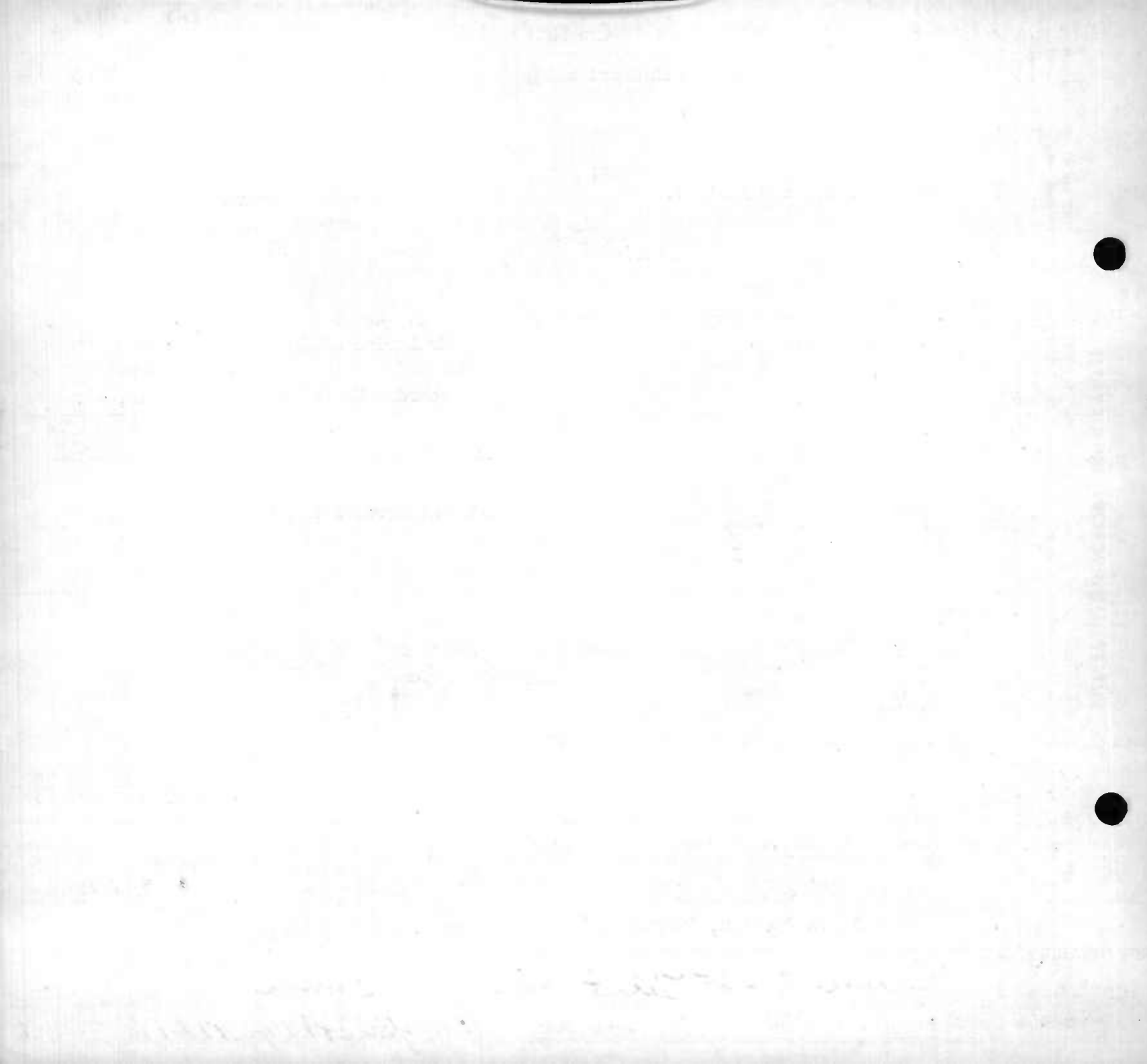


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 7407 | | CERTIFICATE OF DEATH | | Registered No. 65 7407 | | |
|---|-----------------------|---|-------------------------------------|--|--|---|--|------------------------------------|---------|--|
| 1. NAME OF DECEASED
(Type or Print) Blanche Elizabeth Cheatham | | | | 2. DATE AND HOUR OF DEATH
July 13, 1965 | | 7:05 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital,
Wyman Pk. Drive & 31st St. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE NC
B. COUNTY V-30 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Asheville | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
104 Madison Avenue | | | | | | |
| 5. SEX
F | 6. RACE
Col | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
2/23/15 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
NC | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Jordan Mc Gee | | | | 14. MOTHER'S MAIDEN NAME
Katherine Robinson | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. | | | | ADDRESS | |
| 18. 204.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary edema | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
Terminal | | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO
Acute myelogenous leukemia | | 1 yr. | | | | |
| | | | | (C) DUE TO | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I)/(this hospital) attended the deceased from June 7 19 65 to July 13 19 65 , that (I)/(we) last saw the deceased alive on July 13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE

Thomas J. Lau, Surgeon (R) | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/14/65 | | |
| 23C. PHYSICIAN'S NAME (Print)
Thomas J. Lau, Surgeon (R) | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
7/14/65 | | 24C. NAME OF CEMETERY or CREMATORY
Violet Hill | | 24D. LOCATION (City, town, or county) (State)
Emma N.C. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR
William S. Phillips | | ADDRESS
1727 N. Monmouth St. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

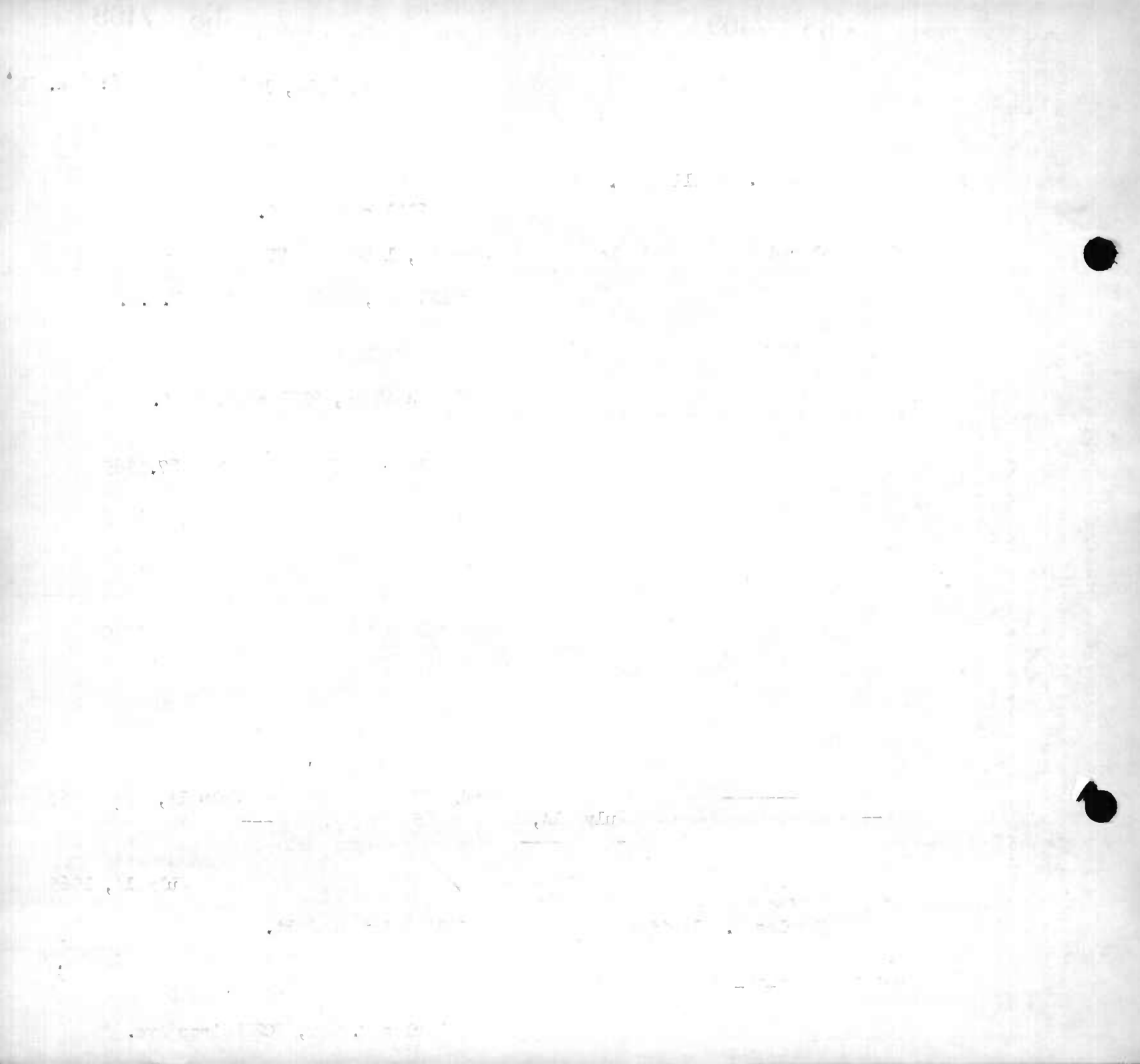
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7408 | |
|--|------------------|--|------------------------------------|--|--|
| BIRTH NO. 65 7408 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) NATHAN BELKIN | | 2. DATE AND HOUR OF DEATH
7/14/65 10:30 AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
CHURCH HOME AND HOSPITAL | | A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 5039 E WOODGATE COURT | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
4/16/12 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
GROCER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Russia | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
MAX BELKIN | | 14. MOTHER'S MAIDEN NAME
MARY STATLEN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
224-09-2909 | | 17. INFORMANT
CHART | |
| 18. 422.21
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute pyelonephritis | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
14 days | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
myocardial hypertrophy with failure. | | (A) DUE TO | | (B) DUE TO | |
| | | (C) Pulmonary edema | | 10 yrs +
2 days | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 14 1965 to July 14 1965 , that (I) (we) last saw the deceased alive on July 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Nahum | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7.15.65 | |
| 23C. PHYSICIAN'S NAME (Type)
A. NAHUM | | 23D. ADDRESS
Church Home | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/16/1965 | | 24C. NAME of CEMETERY or CREMATORY
ARLINGTON | |
| 24D. LOCATION (City, town, or county) (State)
BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farker, M.D. | | 25C. FUNERAL DIRECTOR
SYLVAN S. LEWIS & SON, INC. | | | |
| ADDRESS
3319 OLYMPIA AVE | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 7409 | |
|---|---------|--|--|--|---------------------------------|
| BIRTH NO. | | | | 65 7409 | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| REGINA EDGERTON WRIGHT | | | JULY 14, 1965 6: A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION

2121 N. McCulloh St. | | | A. STATE
MARYLAND
B. COUNTY | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 2121 McCulloh St. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months; Days |
| Female | Colored | Single | June 27, 1988 | 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| TEACHER | | | | BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| CALVIN WRIGHT | | | U.S.A. | | |
| 14. MOTHER'S MAIDEN NAME | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| MARY BLAND | | | NO | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| | | | MARY FERNANDEZ, 2121 McCulloh St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | (A) CHRONIC MYOCARDITIS MARCH 23, 1965 | | |
| ANTECEDENT CAUSES | | | (B) ARTERIOR SCLEROSIS 1965 | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DIABETIC MELLITUS 1960 | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | DIABETIC MELLITUS 1960 | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| None | | None | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 27, 1965 to July 14, 1965, that (I) (we) last saw the deceased alive on July 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| <i>Charles P. Clautice</i> | | | | July 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Charles P. Clautice | | | | 3013 Saint Paul St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 7-17-65 | | ARBUTUS | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| JUL 16 1965 | | <i>Robert E. Fawcett</i> | | Charles R. Law, 802 Madison Ave. | |

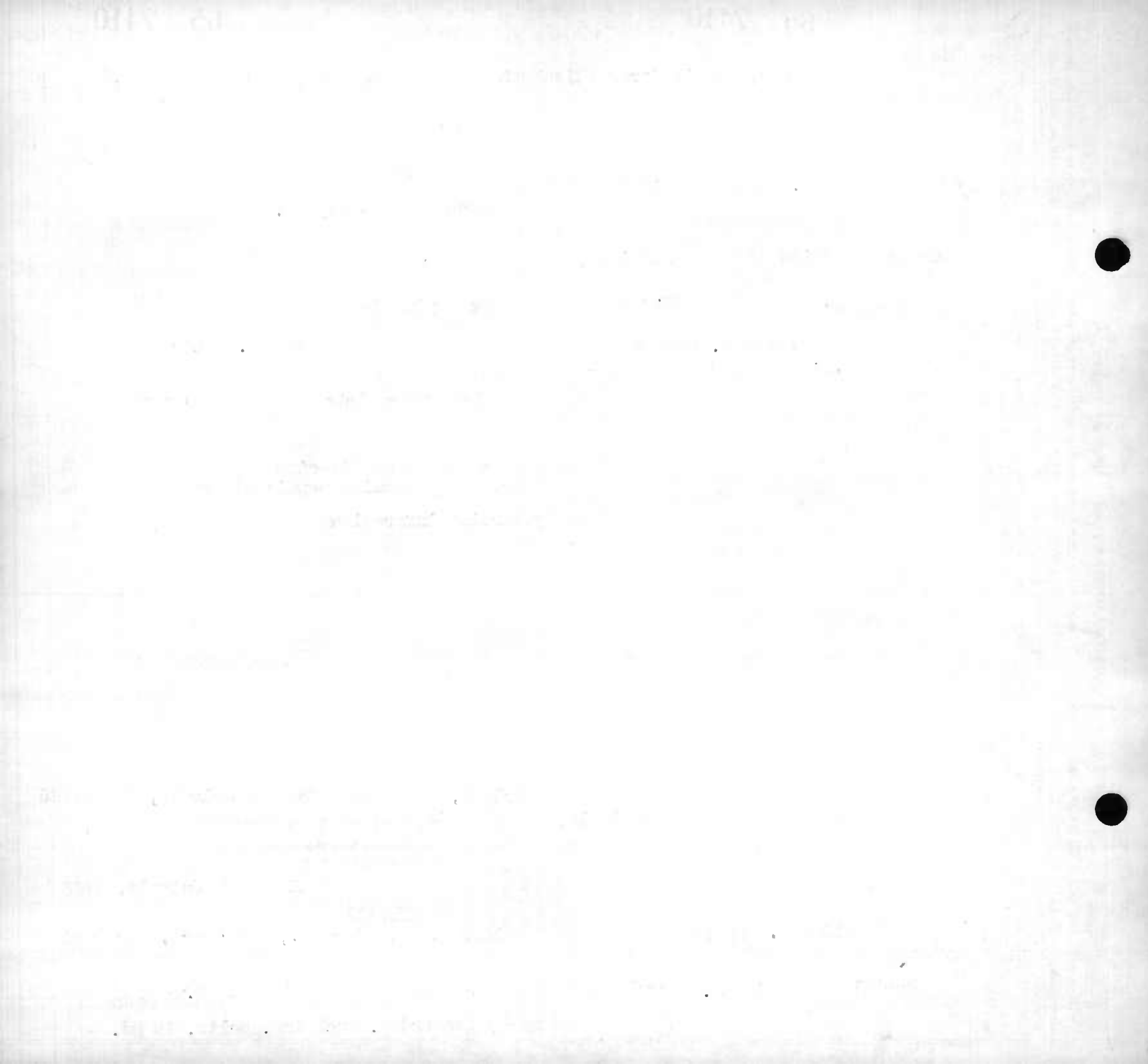


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7410 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7410 | |
|--|--|--|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Rohe, Bessie Sarah Elizabeth | | | | 2. DATE AND HOUR OF DEATH
July 14, 1965 11:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-06 | | | |
| 5. SEX Female | | | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 8. DATE OF BIRTH May 13, 1887 | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | | | 9. AGE (In years last birthday) 78 | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Martin W. Porter | | | | 14. MOTHER'S MAIDEN NAME Emma K. Peters | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Miss Thelma Rohe (Same) | |
| 18. 7-20-1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Gastro-Intestinal bleeding probable bleeding peptic ulcer
ANTECEDENT CAUSES
Myocardial infarction
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Gastro-Intestinal bleeding probable bleeding peptic ulcer
(B) Myocardial infarction
(C) _____ | | | |
| 19A. DATE OF OPERATION _____ | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7, 19 65 to July 14, 19 65 , that (I) (we) last saw the deceased alive on July 14, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Elmo M. Gayoso | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED July 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Elmo M. Gayoso | | | | 23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | | 24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 16 1965 | | 25B. NAME OF REGISTRAR Robert E. F. ... | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14 Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7411 | |
|--|------------------------------|--|---|--|--|
| BIRTH NO. 65 7411 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Bowling, Oliver T. | | 2. DATE AND HOUR OF DEATH
July 14 1965 9.10P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Josephs Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3030 California Ave. 21234 | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
8-20-1900 | 9. AGE (In years last birthday)
64 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 10B. KIND OF BUSINESS OR INDUSTRY
General Electric Co. | | 11. BIRTHPLACE (State or foreign country)
Maryland | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Charles O. Bowling | | | 14. MOTHER'S MAIDEN NAME
Kate Kroeger | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes WW 1 | | 16. SOCIAL SECURITY NO.
216-05-8041 | | 17. INFORMANT
Mrs. Rosalind Bowling | |
| | | | | ADDRESS
(Same) | |
| 18. 331X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Left cerebral hemorrhage | | CAUSE OF DEATH
(A) Left cerebral hemorrhage
DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B)
DUE TO | | | |
| (C)
DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 14 1965 to July 14 1965 , that (I) (we) last saw the deceased alive on July 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>William B. VandeGrift</i> | | | | 23B. DATE SIGNED
July 15, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
William B. VandeGrift, M.D. | | 23D. ADDRESS
1400 N. Caroline St. Baltimore 21213 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7/19/65. | 24C. NAME of CEMETERY or CREMATORY
Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
Leonard J. Ruck Inc. Balto. 14 Md. | |

1775 50

NOT

Office of Insurance

| 1 | | 65 7412 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 7412 | |
|---|-----------|--|------------------|---|--|--|--|
| BIRTH NO. | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| FRANK Francis WOJCIECHOWSKI | | | | July 15, 1965 | | 7:30 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | B. COUNTY | |
| St. Joseph's Hospital | | | | Maryland | | Balt | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | 6300 | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 6011 Westwood Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | | |
| Male | Caucasian | married | Sept 22, 1906 | 58 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Meat Cutter | | Food Fair | | Baltimore, Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Michael Wojciechowski | | | | Josephine Klich | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | Mrs. Clara Wojciechowski, | | same | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Hypertensive and Arteriosclerotic Cardiovascular Disease. | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 7/16/65 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 7/20/65 | | St. Stanislaus Cem. | | Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 16 1965 | | Robert E. Farley | | Leonard J. Ruck Inc | | 5305 Harford Rd. | |

WALTER E. BROS.

Charles E. B.

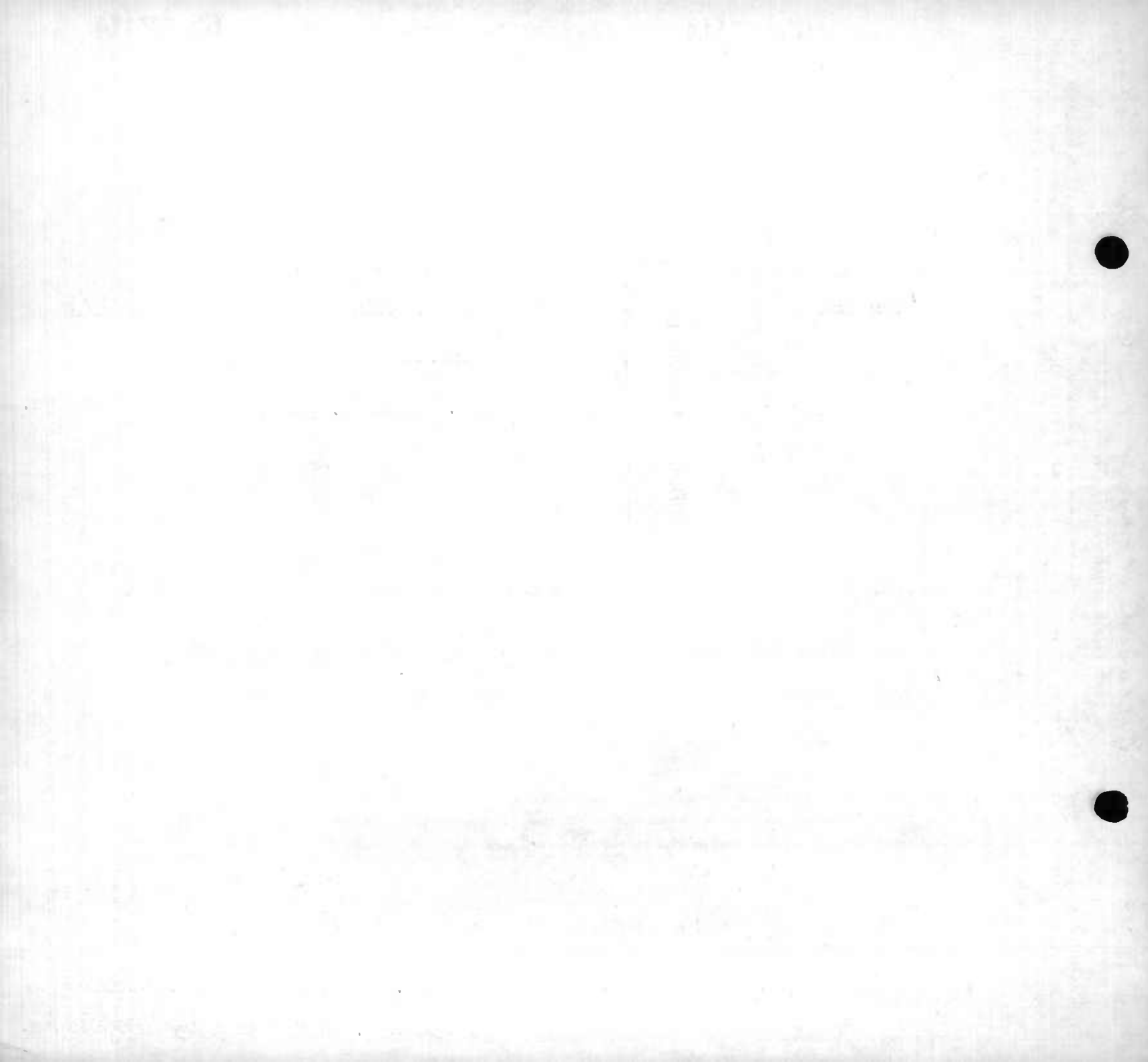
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7413 | |
|---|--|--|--|--|--|
| BIRTH NO. 65 7413 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Loretta Bauhaus R. Bauhaus | | 2. DATE AND HOUR OF DEATH 7/15/65 11:40 11:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)
Union Memorial Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY Balto | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Thomas Cassidy | | 14. MOTHER'S MAIDEN NAME Mary Kenny | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Mary D. Wright ADDRESS Balto., Md. | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) CORONARY ARTERY DISEASE - M.I. DUE TO (B) Previous History of 2 Myocardial Infarcts DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 9:00 - 11:40 AM 7/15/65 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 9:35 AM 7/15 1965 to 11:40 AM 7/15 1965, that (we) last saw the deceased alive on 11:40 AM 7/15 1965 and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE DR. HARRY J. BROWN | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. HARRY J. BROWN | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/19/65 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery, Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md. | |

Released for approval by Med Exam.
FUNERAL DIRECTOR: IMPORTANT

| | | | | | |
|--|-----------|---|---|---|--|
| BIRTH NO. 65 7414 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7414 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) KATRINA STASIKAUNAS | | 2. DATE AND HOUR OF DEATH JULY 16, 1965 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY 3-D | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSP., BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 804 STILES ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 1875 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Lithuania | | 12. CITIZEN OF WHAT COUNTRY? Lithuania |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME Katherine Griegacaci | | 17. INFORMANT Mrs. Agnes A. Genco 6413 Walther Ave. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) PULMONARY EDEMA (B) CNF (C) HASCVD | | INTERVAL BETWEEN ONSET AND DEATH 74 hrs 74 hrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. BRONCHOPNEUMONIA, FX @ FEMUR | | | | | |
| 19A. DATE OF OPERATION 1/7/14/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FX @ FEMUR | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 804 STILES ST. | |
| 21D. TIME OF INJURY (APPROX.) 7 10 '65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FELL IN BACK YARD | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-10 19 65 to 7-16 19 65, that (I) (we) lost saw the deceased alive on 7-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David J. Gillis M.O. | | 23B. DATE SIGNED 7/16/65 | | 23C. PHYSICIAN'S NAME (Type) DAVID J. GILLIS M.O. | |
| 23D. ADDRESS MERCY HOSP. BALTO. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/19/65 | | 24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem. | |
| 24D. LOCATION Baltimore, Maryland | | 24E. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc 5305 Harford Rd. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 16 1965 | | 25B. NAME OF REGISTRAR P. L. B. E. F. D. M. | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc 5305 Harford Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 7415 | |
|--|-----------|--|--------------------------|--|--------------------------------|
| BIRTH NO. 65 7415 | | CERTIFICATE OF DEATH | | Registered No. 65 7415 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Levi 9. Butterbaugh | | 2. DATE AND HOUR OF DEATH 7-13-65 8:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | 5. COUNTY - BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital | | A. STATE PA | | B. CITY OR TOWN TYRONA | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) 1451 Bald Eagle Ave | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2-16-91 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper mill (ret) | | 10B. KIND OF BUSINESS OR INDUSTRY Paper mill | | 11. BIRTHPLACE (State or foreign country) Philadelphia ALTOONA PA | |
| 13. FATHER'S NAME Samuel Butterbaugh | | 14. MOTHER'S MAIDEN NAME Margaret Tyler | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO | | 16. SOCIAL SECURITY NO. 178-10-2389 | | 17. INFORMANT PATIENT | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH A Myocardial Infarction, Abdominal Aortic Aneurysm | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO | | (B) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Presumptive Cancer, Stomach | | | |
| 19A. DATE OF OPERATION 1-27-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED aortic aneurysm | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-24-65 1965 to July 13 1965, that (I) (we) last saw the deceased alive on July 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE asst. mdr | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. A.S.C. Gerardo | | M.D. | | 23D. ADDRESS Church Home & Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-16-65 | | 24C. NAME OF CEMETERY OR CREMATORY Spring Mount | |
| 24D. LOCATION (City, town, or county) (State) Union Neck, Huntington Co. Pa. | | 24E. DATE REC'D BY HEALTH DEPT. JUL 16 1965 | | 24F. NAME OF REGISTRAR Robert E. Fairchild | |
| 24G. FUNERAL DIRECTOR | | 24H. ADDRESS | | 24I. NAME OF REGISTRAR | |
| 24J. DATE REC'D BY HEALTH DEPT. | | 24K. NAME OF REGISTRAR | | 24L. FUNERAL DIRECTOR | |
| 24M. DATE REC'D BY HEALTH DEPT. | | 24N. NAME OF REGISTRAR | | 24O. FUNERAL DIRECTOR | |

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "M", "W", "M", "W", "M", "W" are visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|--|---|---|---|--|--|
| BIRTH NO. 65 7416 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 7416 | | | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Rennie Charles</u> | | | | | 2. DATE AND HOUR OF DEATH
<u>7/14/65</u> <u>11:15 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>University Hospital</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE <u>Baltimore, Md</u>
B. COUNTY <u>5300</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore, Md</u>
D. STREET ADDRESS (If rural, give location) | | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Widower</u> | 8. DATE OF BIRTH
<u>6/7/92</u> | 9. AGE (In years last birthday)
<u>73</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unknown</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>Carpentry</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>Unknown</u> | | | 17. INFORMANT
<u>Son</u> | | | ADDRESS | | | |
| 18. <u>309X I</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

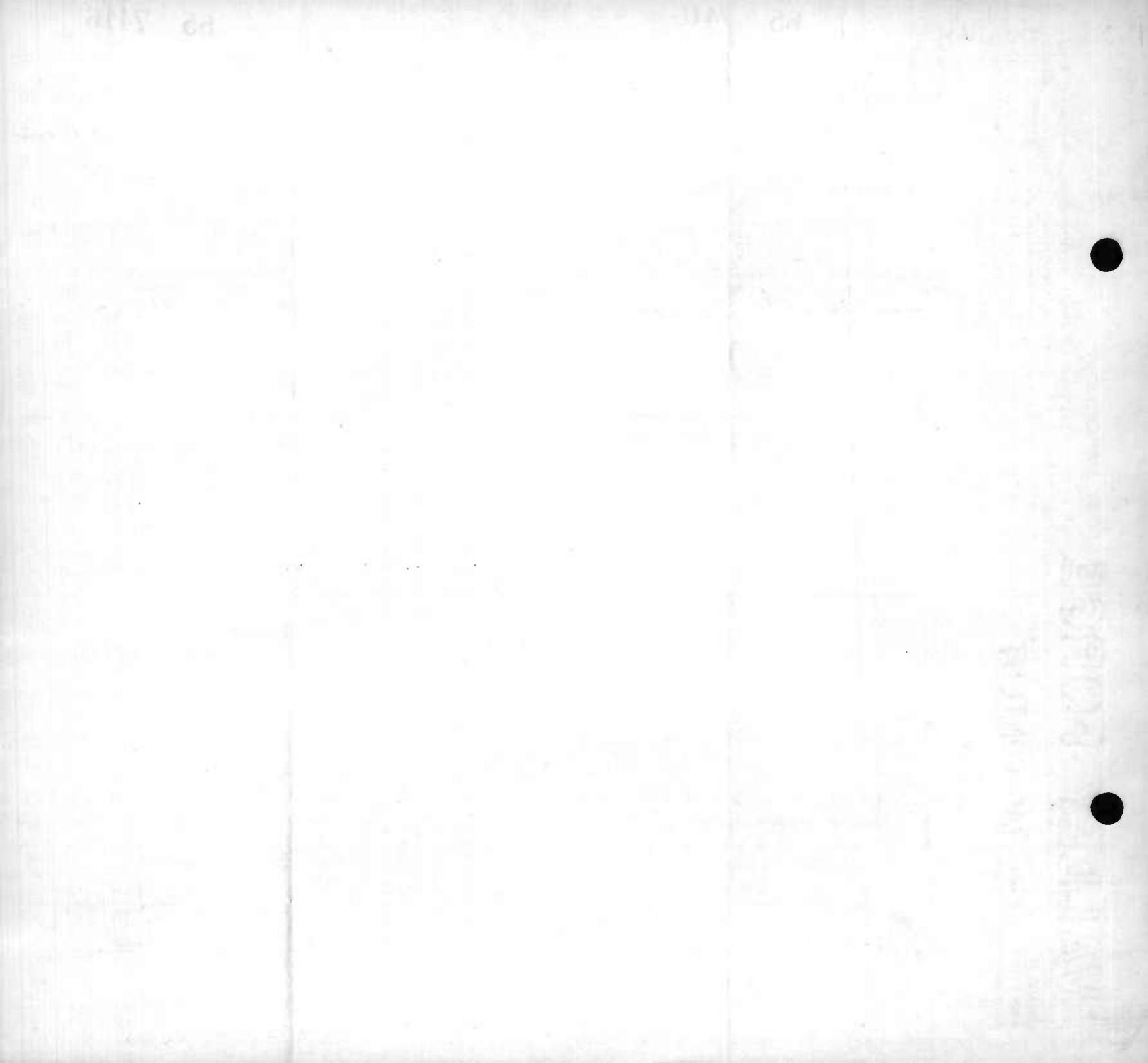
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<u>Chronic Pyelonephritis</u> | | | | | (A) <u>Acute Gastric dilatation</u>
DUE TO

(B) <u>duodenal ulcer with obstruction</u>
DUE TO
<u>hemorrhage</u>

(C) <u>Chronic Brain Syndrome</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>(suspected 3 days)</u>

<u>(suspected chronic)</u> | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>Yes (not completed)</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>July 12, 1965</u> to <u>July 14, 1965</u> , that (I) (we) lost saw the deceased alive on <u>15 PM July 14, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<u>Harold C Standiford</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
<u>July 14, 1965</u> | | | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Harold C Standiford</u> | | | | 23D. ADDRESS
<u>University Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>7/17/65</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Hollywood Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State)
<u>Richmond Virginia</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 16 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farkner</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Ambrise Inc. 1328 Sudham Rd Ref</u> | | | | | |

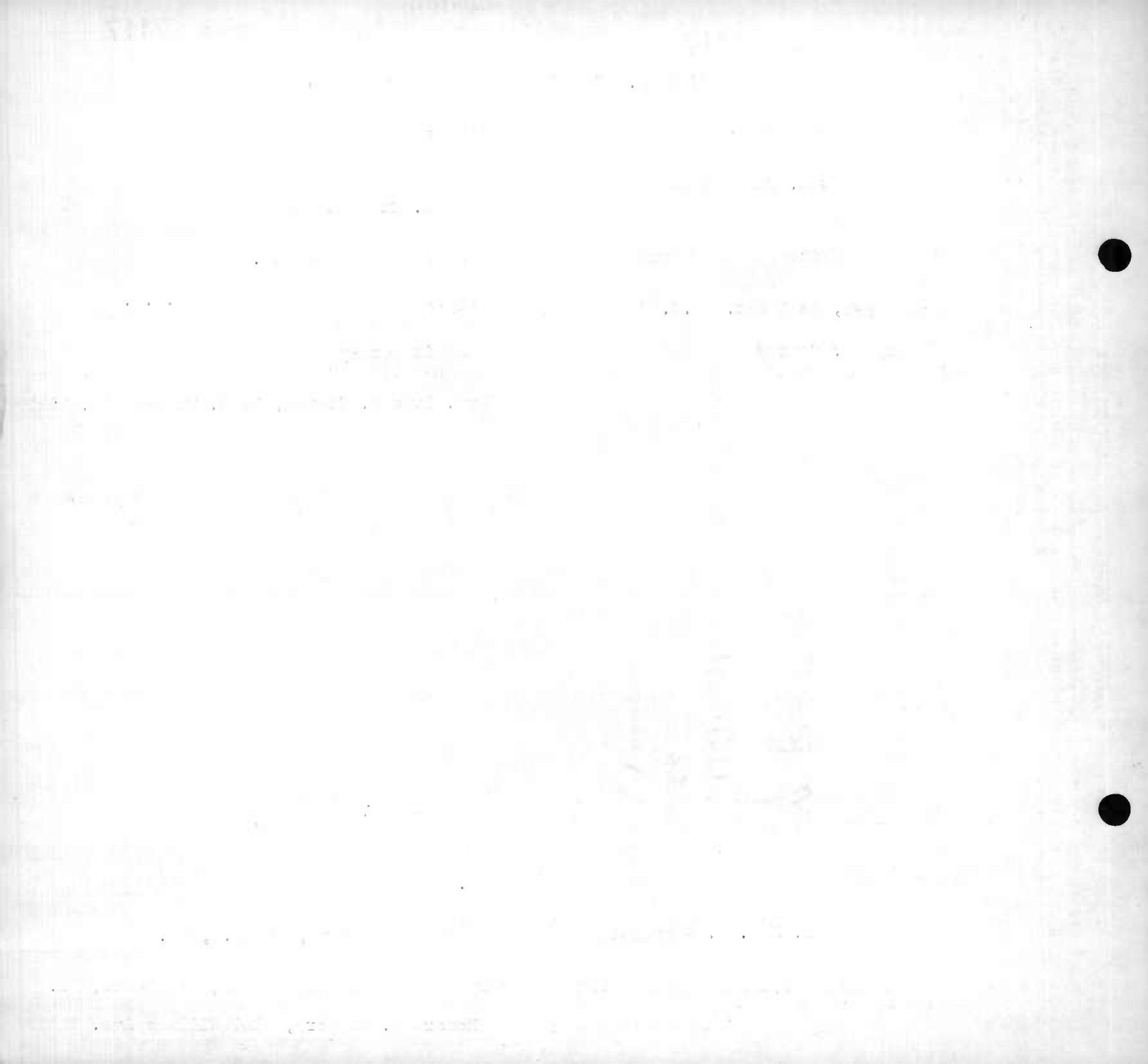


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 7417</u> | |
|---|-------------------------|--|--------------------------------------|--|---|
| BIRTH NO. <u>65 7417</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>CALVIN WALTER S. GEORGE</u> | | 2. DATE AND HOUR OF DEATH
<u>July 14, 1965</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

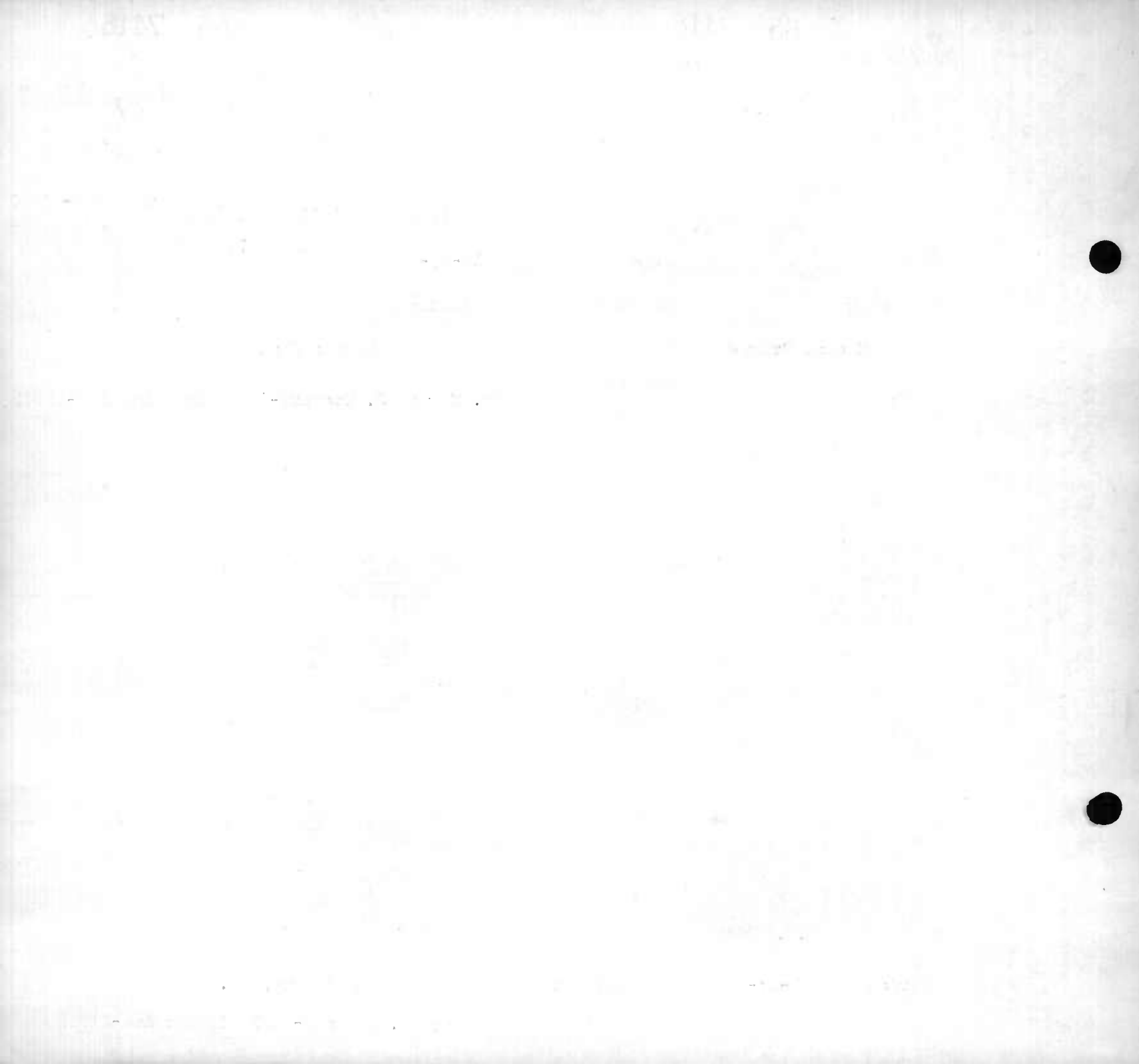
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
<u>20 N. Tremont Road</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <u>Maryland</u>
B. COUNTY <u>Baltimore</u>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>Baltimore</u>
D. STREET ADDRESS (If rural, give location)
<u>20 N. Tremont Road</u> | | | |
| 5. SEX
<u>Male</u> | 6. RACE
<u>White</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>Married</u> | 8. DATE OF BIRTH
<u>8/10/1905</u> | 9. AGE (In years last birthday)
<u>59 Yrs.</u> | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Machinist, Semi Ret.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>U.S. Government</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Harry E. George</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annie Dorsey</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<u>Mrs. Irma M. George, 20 N. Tremont Rd. 21229</u> | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the made at dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
<u>Adenocarcinoma generalized</u>
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<u>Primary in sigmoid</u> | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 years</u> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1</u> 19 <u>56</u> to <u>July 14</u> 19 <u>65</u> , that (I) (was) last saw the deceased alive on <u>July 3</u> 19 <u>65</u> and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>John F. Schaefer</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<u>July 15 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>Dr. Jno. F. Schaefer</u> | | 23D. ADDRESS
<u>401 Random Road, Balto., Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>7/17/65</u> | | 24C. NAME of CEMETERY or CREMATORY
<u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Wilkins Avenue, Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 16 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR ADDRESS
<u>Howard H. Hubbard, 4107 Wilkins Ave. 21229</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

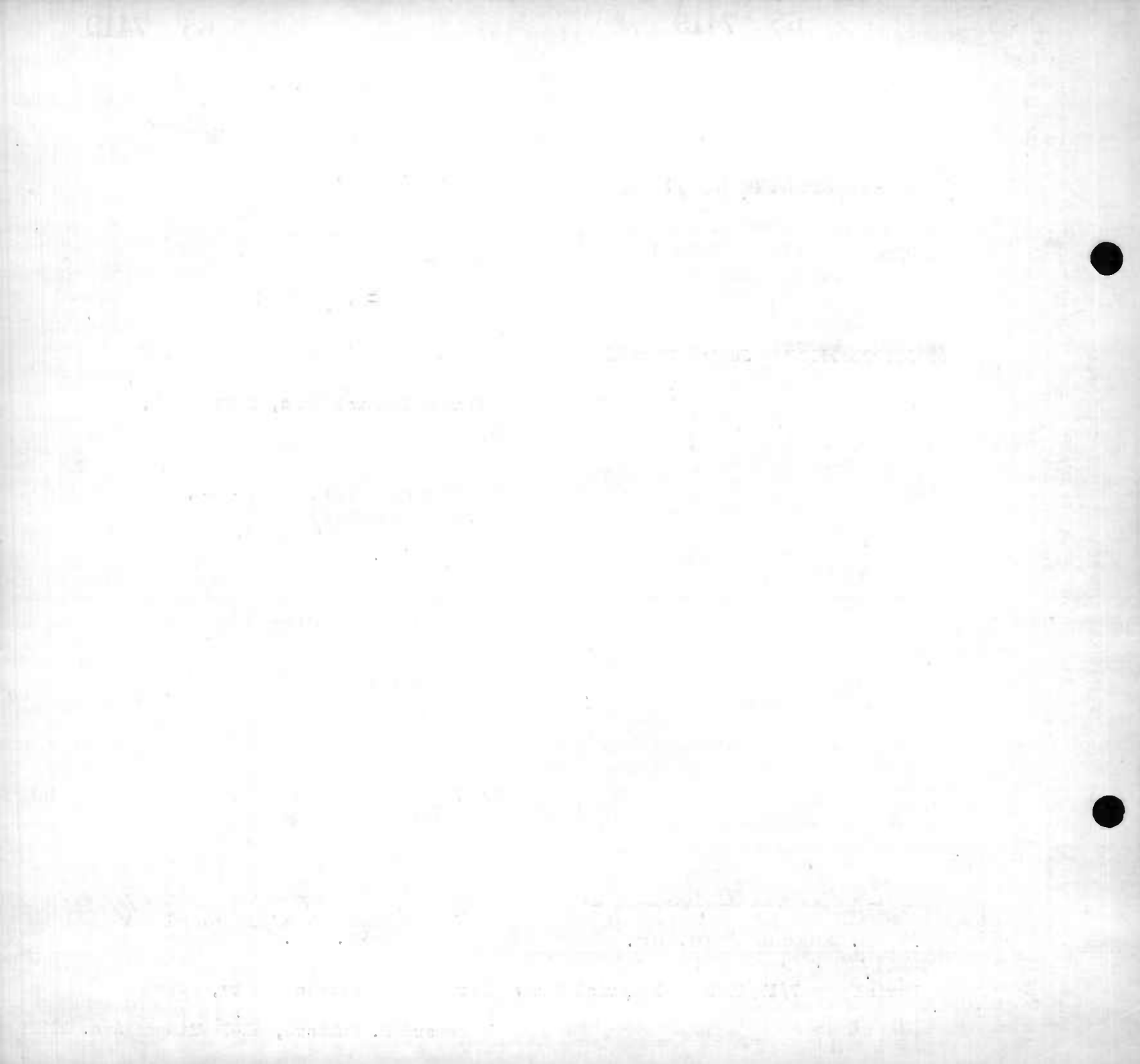
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 7418 | | CERTIFICATE OF DEATH | | Registered No. 65 7418 | |
|--|--|---|--|--|--|---|--|--|--|
| BIRTH NO. | | | | M.E. CASE NO. | | 1. NAME OF DECEASED <i>ELIZABETH TRAVERS</i> | | 2. DATE AND HOUR OF DEATH
<i>JULY 13, 1965</i> <i>3:00 A.M.</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
<i>LUTHERAN HOSPITAL OF MARYLAND</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE <i>MARYLAND</i> B. COUNTY <i>15-10</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i> | | D. STREET ADDRESS (If rural, give location)
<i>3501 Berwin Ave-21207</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | 5. SEX
<i>FEMALE</i> | | 6. RACE
<i>WHITE</i> | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>WIDOW</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Homemaker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | | 8. DATE OF BIRTH
<i>10-27-94</i> | | 9. AGE (In years last birthday) <i>70</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 11. BIRTHPLACE (State or foreign country)
<i>Scotland</i> | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 13. FATHER'S NAME
<i>Thomas Grieve</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Rosina Sharp</i> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
<i>Mr. Thomas J. Travers-4831 Clayberry Ave-21212</i> | |
| 18. <i>49-3X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)
<i>Pneumonia</i> | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>48 hrs.</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
<i>Arteriosclerotic Parkinsonism</i> | | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>July 11</i> 19 <i>65</i> to <i>July 13</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>July 13</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>F. S. REROMA</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
<i>July 13, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>F. S. REROMA</i> | | | | M.D. 23D. ADDRESS | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7-16-65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>New Cathedral</i> | | 24D. LOCATION (City, town, or county) (State)
<i>Baltimore, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 16 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Howard H. Hubbard-4107 Wilkens Ave-21229</i> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 7419 | |
|--|-------------------------|---|---|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 65 7419 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Phoebe Meadows | | | 2. DATE AND HOUR OF DEATH
2:00 A.M. 7/14/65 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL | | | A. STATE MARYLAND
B. COUNTY BALTIMORE, 34 | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, 34 | | |
| | | | D. STREET ADDRESS (If rural, give location)
3013 ORLANDO AVE | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
MARRIED | 8. DATE OF BIRTH
1-23-83 | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Lewis County, Kentucky | |
| 13. FATHER'S NAME
JOSEPH KIDWELL | | 14. MOTHER'S MAIDEN NAME
FAIRLEAN Stamper | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Rmrick Funeral Home, Portsmouth, Ohio | |
| 18. 472X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Renal Disease | | | INTERVAL BETWEEN ONSET AND DEATH
10 days | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO
Arteriosclerotic Cardio-vascular disease
(B) DUE TO
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Possible Pulmonary Embolus | | |
| 19A. DATE OF OPERATION
2 none | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
NO | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 6/27 19 65 to 7/14 19 65 , that (X) (we) last saw the deceased alive on July 13 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE
E. Eugene Page, Jr. | | | | 23B. DATE SIGNED
7/14/65 | |
| 23C. PHYSICIAN'S NAME (Type)
E. Eugene Page, Jr. | | | | 23D. ADDRESS
Johns Hopkins Hospital
Balt. Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/17/1965 | | 24C. NAME of CEMETERY or CREMATORY
Memorial Burial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State)
Scioto County, Ohio | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fairbairn | | 25C. FUNERAL DIRECTOR ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |



65 7420

BALTIMORE CITY HEALTH DEPARTMENT

65 7420

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROGER LYNN CUMBERLAND

2. DATE AND HOUR PRONOUNCED DEAD

July 14, 1965 4:10 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4323 Cedar Garden Road

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4323 Cedar Garden Road

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11/11/1929

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Line type operator

10B. KIND OF BUSINESS OR INDUSTRY

King Publishing

11. BIRTHPLACE (State or foreign country)

BALTO. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

LYNN Cumberland

14. MOTHER'S MAIDEN NAME

Catherine Brosenne

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

4323 Cedar Garden Rd.
Mrs. Rosalie M. Cumberland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
7/15/6523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/17/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem. BALTO.

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 16 1965

24B. NAME OF REGISTRAR

R. E. Fadden

24C. FUNERAL DIRECTOR

G. Truman Schwalb

ADDRESS

3512 Frederick Ave.

VALLEY FOUNDER

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

ANNA A. NEAL

2. DATE AND HOUR PRONOUNCED DEAD

July 13, 1965 12:17 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1025 Pennsylvania Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

April 6, 1921

9. AGE (in years
lost birth)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Work

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Archie Neal

14. MOTHER'S MAIDEN NAME

Alberta Waters

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Juanita Neal 3005 45th Street, N. W.
Washington, D. C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty Liver and Cirrhosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 17, 1965 Emory Grove

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Emory Grove, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 16 1965

Robert E. Johnson

Robert L. Snowden Rockville, Md.

VALLEY FORGE

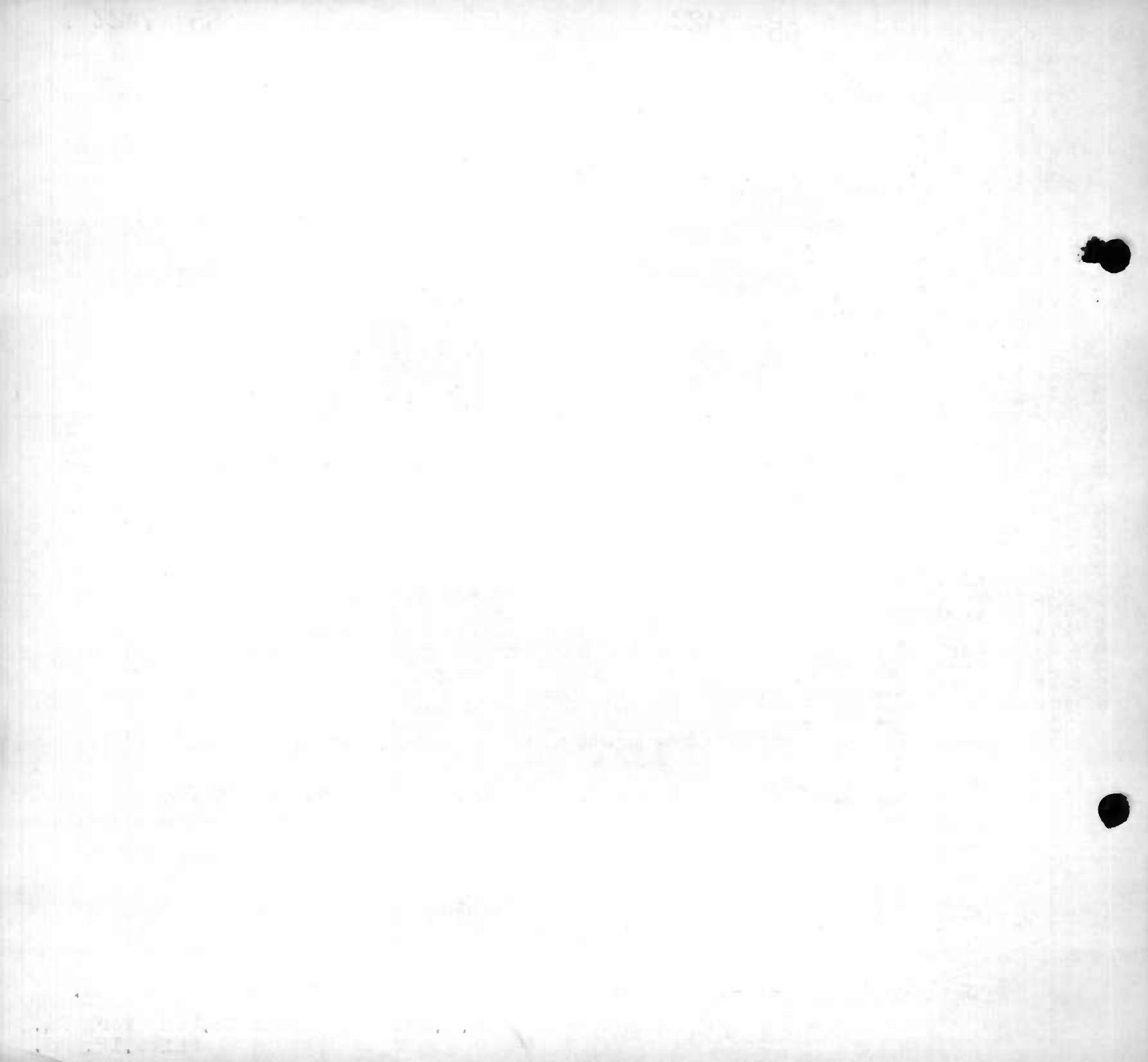
[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7422 | |
|---|------------------|--|--|--|--|
| BIRTH NO. 65 7422 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) MARY W. WHITRIDGE | | 2. DATE AND HOUR OF DEATH
7/15/65 4:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hosp | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY 27-14
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
608 Somerset Rd | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 2/9/02 | 9. AGE (In years lost birthday) 63 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
h. wife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Md | |
| 13. FATHER'S NAME
Charles Webb | | | 14. MOTHER'S MAIDEN NAME
Mary Cator | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Mr. W.B. Buck 2 Merryman Ct | |
| 18. 446 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Anteroselective Heart Disease
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Vascular Nephritis (Nephrosclerosis) & Uremia | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>the hospital</u>) attended the deceased from 7/4 19 65 to 7/15 19 65 , that (I) (<u>we</u>) last saw the deceased alive on 7/15 19 65 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | |
| 23A. SIGNATURE
B. Williams
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
EDWARD S. STAFFORD M.D. | | | | 23D. ADDRESS
Union Memorial Hosp. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-17-65 | | 24C. NAME OF CEMETERY or CREMATORY
Greenmount | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 16 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



NON MED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|---|-------------------------------|--|---|
| BIRTH NO. 65 7423 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7423 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) Ceola Lunsford | | 2. DATE AND HOUR OF DEATH
7-16-65 3:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY
XXXXXXXXXX MARYLAND 8-05 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
3 THE JOHNS HOPKINS HOSPITAL | | D. STREET ADDRESS (If rural, give location)
1754 E. NORTH AVE. | | | |
| 5. SEX
F | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOW | 8. DATE OF BIRTH
7-26-1914 | 9. AGE (In years lost birthday)
50 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BEADTIE | | 10B. KIND OF BUSINESS OR INDUSTRY
SELF EMPLOYED | | 11. BIRTHPLACE (State or foreign country)
DARLINGTON S.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
EADY MOSES | | 14. MOTHER'S MAIDEN NAME
LUCY FRANKLIN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
2A-22-8131 | | 17. INFORMANT
MINNIE MAE EADY | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
465X+170X | | CAUSE OF DEATH
(A) Probable Pulmonary Embolus
(B) DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH
1 hour | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II Carcinoma Breast | | | |
| 19A. DATE OF OPERATION
7 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-16 19 65 to 7-16 19 65, that (I) (we) last saw the deceased alive on 7-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Lee J. Silver | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
LEE J. SILVER | | 23D. ADDRESS
Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Calvary | |
| 24D. LOCATION (City, town, or county) (State)
A.A. Co Md | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | |
| 25C. FUNERAL DIRECTOR
Margaret P. Hays | | 25D. ADDRESS
6146 61st St | | | |

YES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|--|--|
| BIRTH NO.
65 7424 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7424 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH
JULY 14, 1965 4 30 A.M. | |
| 1. NAME OF DECEASED
(Type or Print) EDWARD J. BITTNER | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
Lutheran Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY a.a.c.o. | | 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Glenburnie 52-00 | | 8. DATE OF BIRTH
9-11-1931 | | 9. AGE (In years lost birthday) 33 | |
| D. STREET ADDRESS (If rural, give location)
203 Chalmers Ave. | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Technician Asst | | 10B. KIND OF BUSINESS OR INDUSTRY
Westinghouse | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Anthony Bittner | |
| 14. MOTHER'S M maiden name
Agnes Babberick | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no none | | 16. SOCIAL SECURITY NO.
218-28-6094 | |
| 17. INFORMANT
Shirley Bittner-203 Chalmers Ave. | | 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION
CORONARY ARTERY DISEASE
INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 2 1964 to July 14 1965, that (I) (we) last saw the deceased alive on July 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Morton M. Krieger | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
July 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
MORTON M. KRIEGER | | 23D. ADDRESS
M.D. 5010 RITCHIE HWY BALTO. 25, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/17/65 | | 24C. NAME OF CEMETERY or CREMATORY
Holy Cross Cemetery | |
| 24D. LOCATION
Ritchie Highway Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR
KRAUSE FUNERAL HOME 1216S Charles St | | | |

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 7425 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7425

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DAISY BELLE REEVES

2. DATE AND HOUR PRONOUNCED DEAD 7/9/65 10:00 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

C. STREET ADDRESS (If rural, give location) 407 N. Carrollton Ave.

5. SEX female

6. RACE colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married

8. DATE OF BIRTH Mar. 28 1918

9. AGE (In years last birthday) 51

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

11. BIRTHPLACE (State or foreign country) Wilson N. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Clarence Dawson

14. MOTHER'S MAIDEN NAME Estelle Bynum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 240-09-7793

17. INFORMANT Mrs. Johnnie Reeves - 407 N. Carrollton Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease DUE TO

ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.)

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK []

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER [] ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER []

DATE SIGNED 7/9/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 7-14-65

23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cent. Baltimore Md

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. JUL 19 1965

24B. NAME OF REGISTRAR Robert E. Parker, M.D.

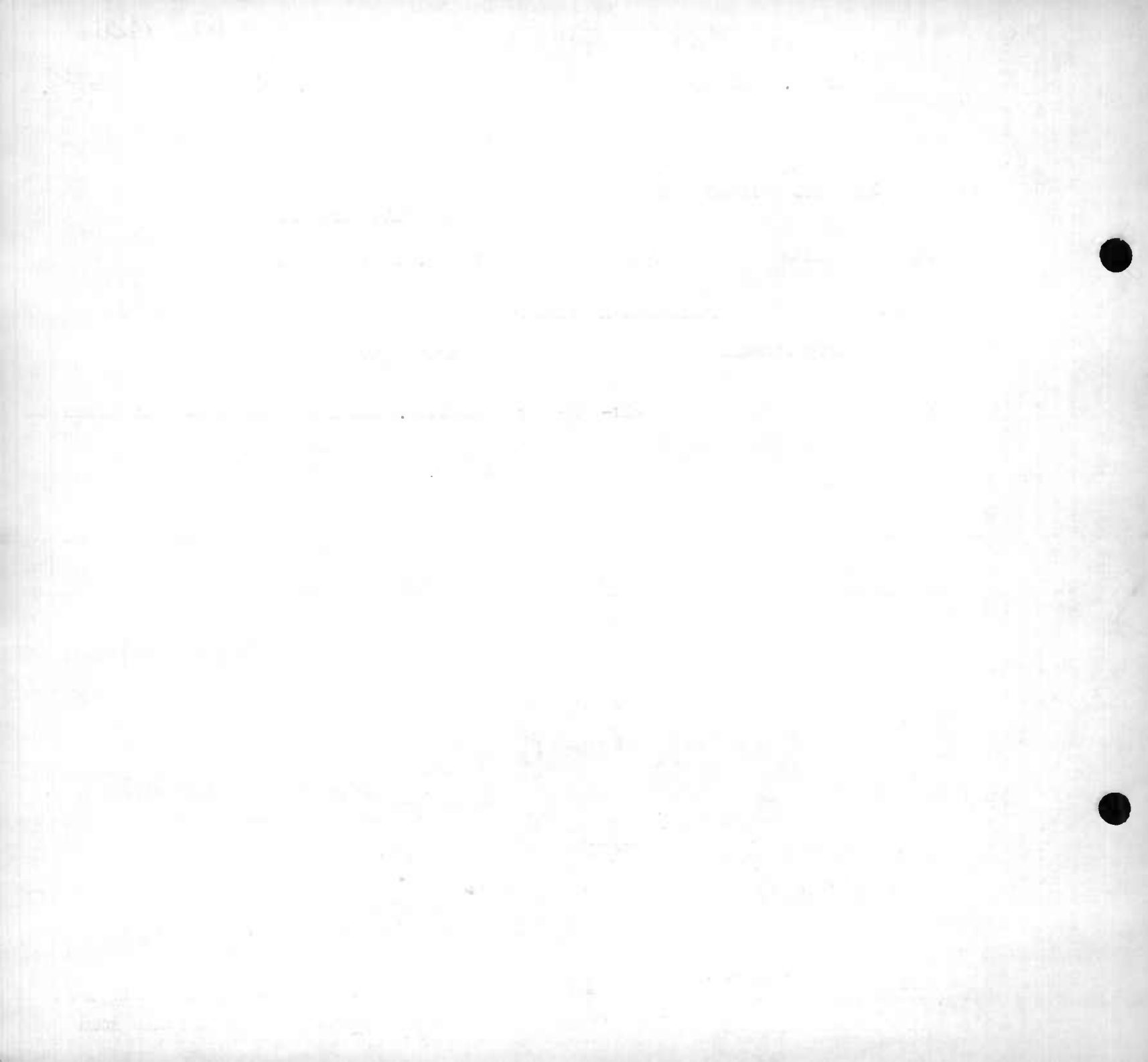
24C. FUNERAL DIRECTOR Joseph C. Rumm 2222 N. North Ave. 512 N. Carrollton Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 7426 | | CERTIFICATE OF DEATH | | Registered No. 65 7426 | |
|--|-------------------------|--|---|--|--|---|--|---|--|
| 1. NAME OF DECEASED
(Type or Print) Harry C. Fanwell | | | | 2. DATE AND HOUR OF DEATH
July 15, 1965 8⁰⁰ p.m. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

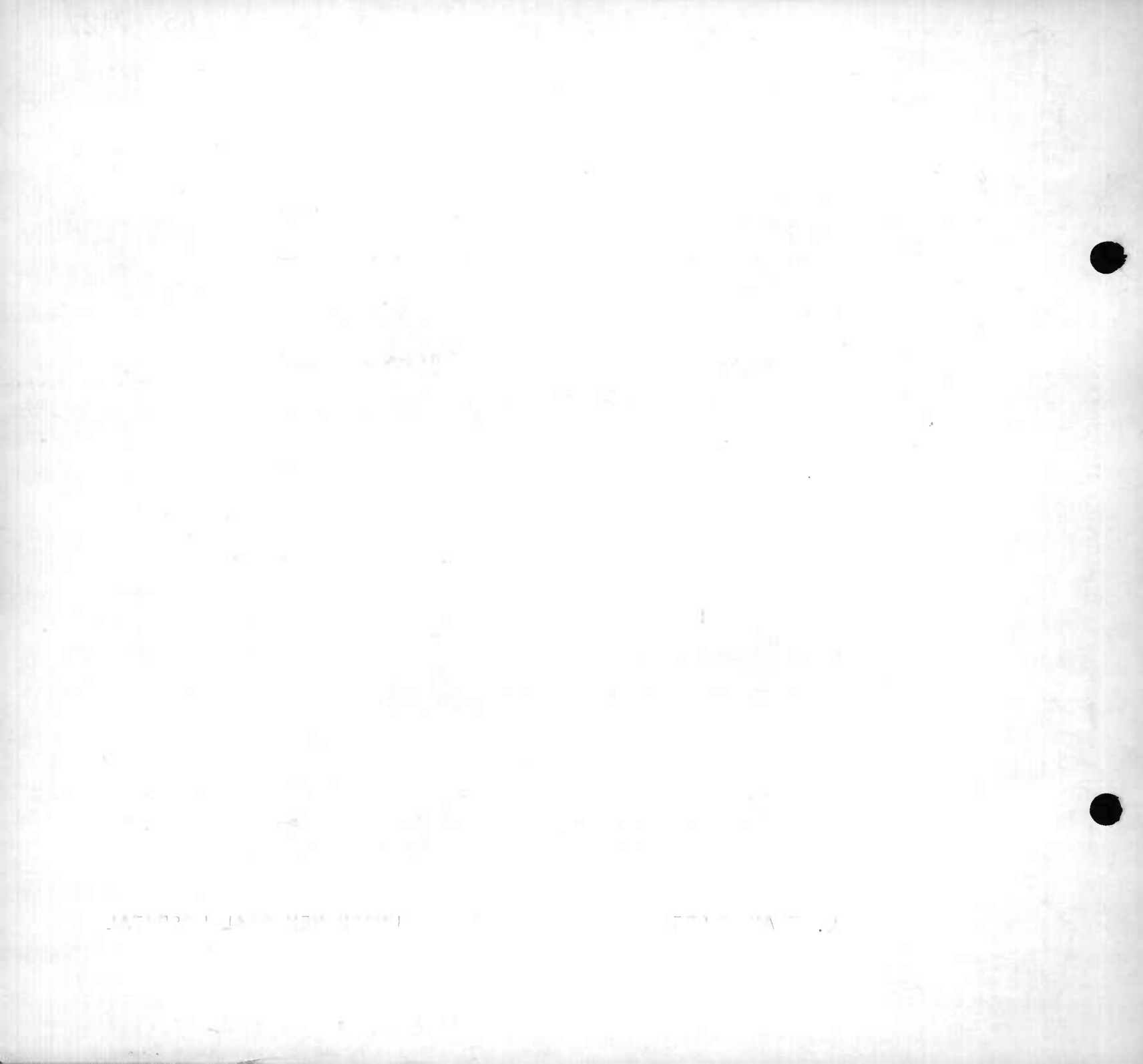
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Long Green Nursing Home
115 East Melrose Avenue | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 13-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2049 Druid Park Drive | | | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
Oct 16, 1886 | 9. AGE (In years lost birthday)
78 | If Under 1 Yr.
Months Days | | If Under 24 Hrs.
Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painting | | | 10B. KIND OF BUSINESS OR INDUSTRY
residential painter | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | |
| 13. FATHER'S NAME
Jerry Fanwell | | | | 14. MOTHER'S MAIDEN NAME
Sarah Taylor | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
217- 01-8975 | | 17. INFORMANT
Lottie O. Fanwell | | | ADDRESS
2049 Druid Park Drive | |
| 18. 450.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Atherosclerosis | | | | (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1952 19 to July 15 19 65 , that (I) (we) last saw the deceased alive on July 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
<i>William G. Helguth</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> MeB. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED
7-16-65 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS
M.D. 5006 Roland Ave Balto 10 Md | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
July 19, 1965 | | 24C. NAME of CEMETERY or CREMATORY
Woodlawn | | 24D. LOCATION (City, town, or county) (State)
Baltimore County Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR
Burgee Funeral Home 3631 Falls Road
By: <i>Harriet Burgee</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 7427</u> | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. <u>85 7427</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <u>HATTIE G. SCHULTHEIS</u> | | 2. DATE AND HOUR OF DEATH
<u>JULY 16, 1965</u> <u>1:45 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<u>UNION MEMORIAL HOSPITAL</u> | | A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> CITY <u>CITY</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location)
<u>616 W. 33RD ST.</u> | | | |
| 5. SEX
<u>F</u> | 6. RACE
<u>WHITE</u> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<u>WIDOWED</u> | 8. DATE OF BIRTH
<u>JULY 29, 1880</u> | 9. AGE (In years last birthday)
<u>84</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY
<u>HOME</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 13. FATHER'S NAME
<u>JOHN E. CORNELIUS</u> | | 14. MOTHER'S MAIDEN NAME
<u>RACHEL BELT</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-44-9667</u> | | 17. INFORMANT
<u>J. RUSSELL SCHULTHEIS</u> | |
| 18. <u>454 X I</u> | | CAUSE OF DEATH | | ADDRESS
<u>2441 ESBURY RD. TIMOTHUM, MA</u> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO
<u>Sepsis due to infected. Haemolysed abdominal aorta</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<u>YES</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (he) (this hospital) attended the deceased from <u>JUNE 29</u> 19 <u>65</u> to <u>JULY 16</u> 19 <u>65</u> , that (we) (we) last saw the deceased alive on <u>JULY 16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<u>L. Evan Custer, M.D.</u> | | | | 23B. DATE SIGNED
<u>July 16, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type)
<u>L. EVAN CUSTER</u> | | | | 23D. ADDRESS
<u>UNION MEMORIAL HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 24B. DATE
<u>July 19-1965</u> | | 24C. NAME OF CEMETERY or CREMATORY
<u>Wood Ridge</u> | |
| 24D. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<u>JUL 19 1965</u> | | 25B. NAME OF REGISTRAR
<u>Robert E. Fickel</u> | | 25C. FUNERAL DIRECTOR
<u>Burgess, Funeral Home 3631 Falls Road</u> | |
| | | | | ADDRESS
<u>Horace F. Burgess</u> | |

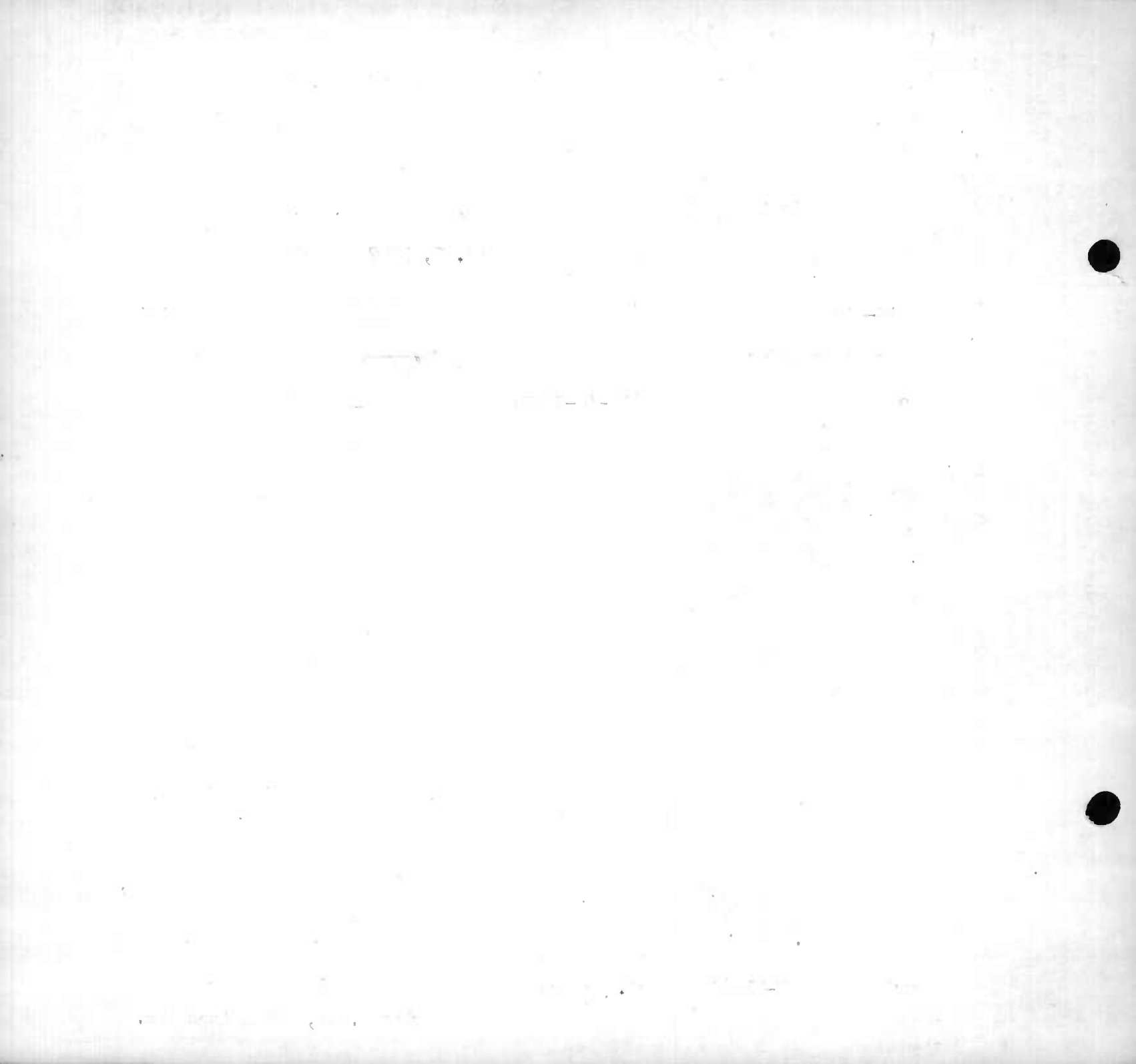


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 7428 |
|---|-----------------------------|--|---|--|
| BIRTH NO. 65 7428 | | | Registered No. 65 7428 | |
| 1. NAME OF DECEASED
(Type or Print) Adrenner Nelson | | | 2. DATE AND HOUR OF DEATH
July 16, 1965 9:30 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 20-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
2519 W. Baltimore Street | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | B. DATE OF BIRTH
Dec. 2, 1897 | 9. AGE (In years lost birthday)
67 ? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ma-Wife | | 10B. KIND OF BUSINESS OR INDUSTRY
none | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 13. FATHER'S NAME
Thomas McFadden | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
227-40-5857a | |
| 17. INFORMANT
Anna Johnson-daughter | | | ADDRESS
same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
443X1
CVA
HCV D + Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Senile decubitus, pneumonia + multiple decubiti | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 29, 1965 to July 16, 1965 , that (I) (we) last saw the deceased alive on July 16, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE
 | | | 23B. DATE SIGNED
July 17, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
A. Rigaud | | | 23D. ADDRESS
M.D. 1514 Division St. Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7-21-65 | 24C. NAME of CEMETERY or CREMATORY
Mt. Auburn | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Falkner | 25C. FUNERAL DIRECTOR ADDRESS
Charles R. Law, 802 Madison Ave. | |

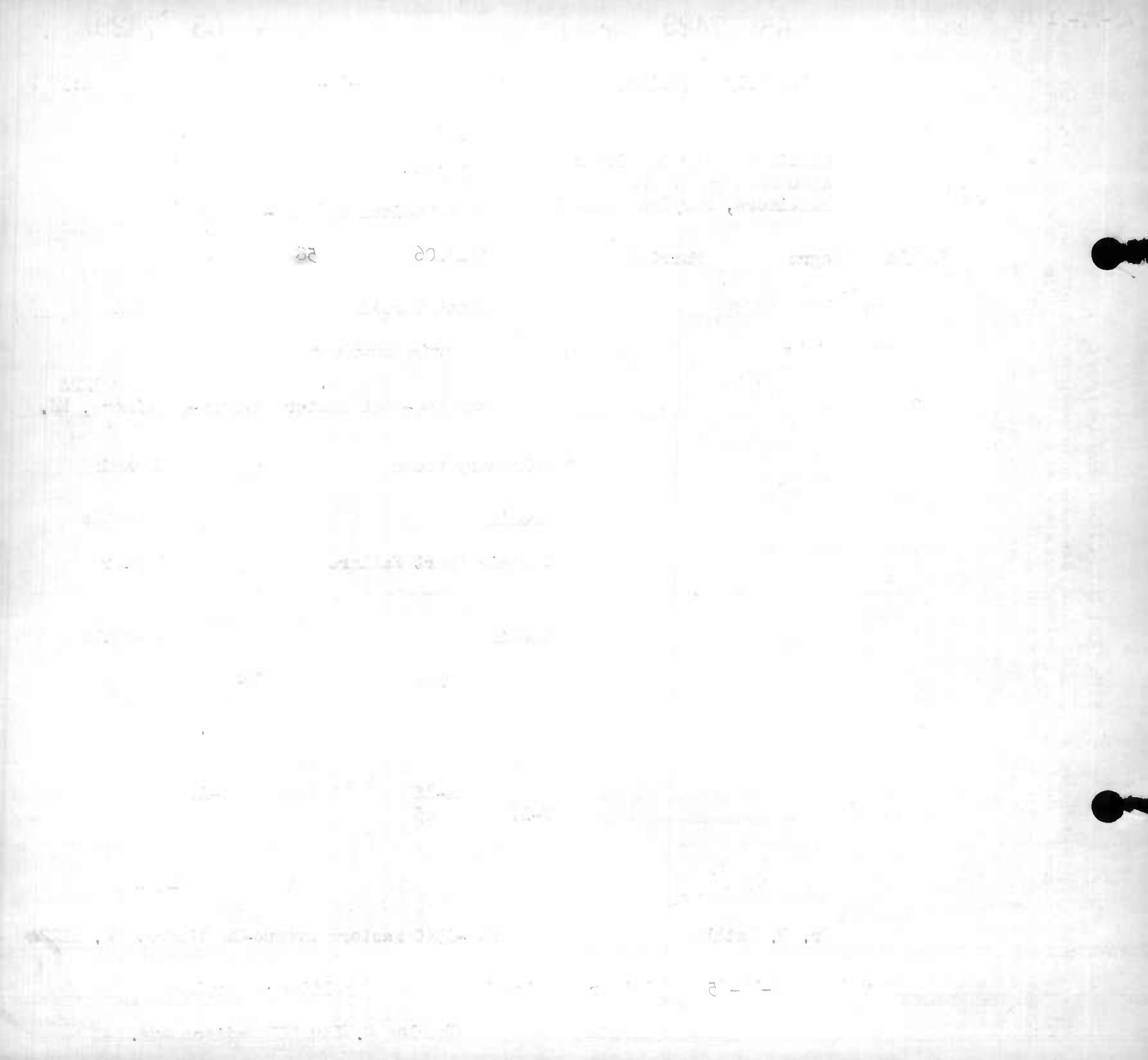


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------------------------|---|--|---|---|
| BIRTH NO. 65 7429 | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. 65 7429 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Thomasina Moly (Holly) | | | 2. DATE AND HOUR OF DEATH
7-17-65 4:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1809 Madison Avenue - #21217 | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
10-4-06 | 9. AGE (In years last birthday)
58 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 13. FATHER'S NAME
Joseph Gibbs | | 14. MOTHER'S MAIDEN NAME
Susie Saunders | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
#21224
RECORDS-4940 Eastern Avenue-Baltimore, Md. | |
| 18. 4-34-2 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
Pulmonary Edema
CAUSE OF DEATH
(A) Pulmonary Edema
DUE TO
(B) Uremia
DUE TO
(C) Chronic Heart Failure
INTERVAL BETWEEN ONSET AND DEATH
1 week
3 months
1 year | | | 19. II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Anemia
INTERVAL BETWEEN ONSET AND DEATH
7 months | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-18 19 65 to 7-17 19 65 , that (I) (we) last saw the deceased alive on 7-17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
H. Rathbun | | | | 23B. DATE SIGNED
7-17-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. N. Rathbun | | 23D. ADDRESS
BCH-4940 Eastern Avenue-Baltimore, Md. 21224 | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
Burial | 24B. DATE
7-22-65 | 24C. NAME of CEMETERY or CREMATORY
Baltimore National | | 24D. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farkas | | 25C. FUNERAL DIRECTOR ADDRESS
Charles R. Law 802 Madison Ave. | |



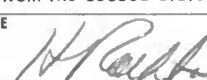
LS: 44-16-03

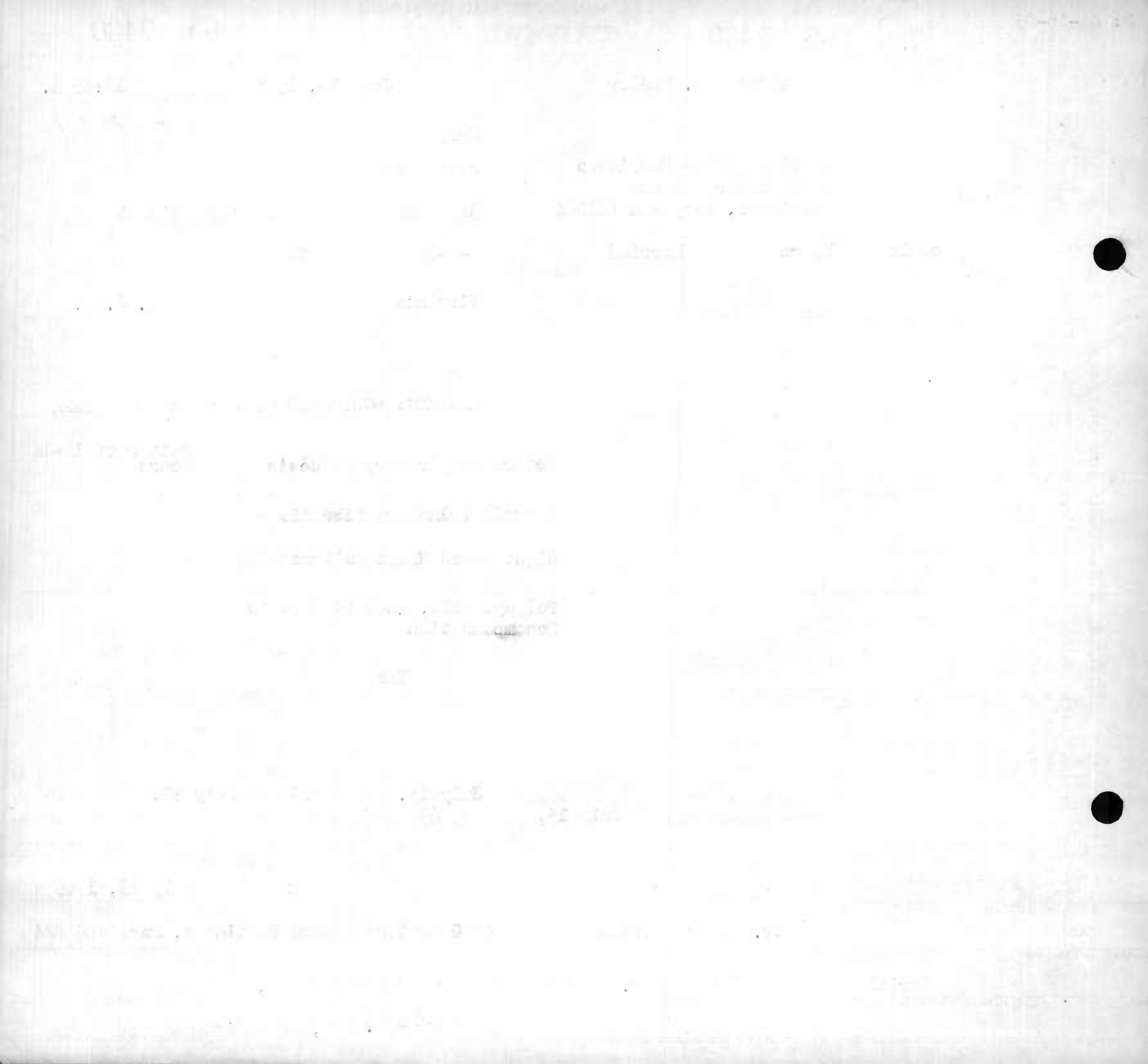
M-340

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decayed D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|--|--|
| BIRTH NO.
65 7430 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7430 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
Alice B. Medley | | | 2. DATE AND HOUR OF DEATH
July 15, 1965 11:55 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3416 Auchentoroly Terrace #21217 | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
9-1-1914 | 9. AGE (In years last birthday)
50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
RECORDS: BCH: 4940 Eastern Avenue #21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Severe Respiratory Acidosis
DUE TO
Chronic Pulmonary Fibrosis
DUE TO
Right Sided Heart Failure | | | INTERVAL BETWEEN ONSET AND DEATH
Matter of 12-24 hours | | |
| 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Polycythemia, Aneuria Hepatic Decomensation | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No)
Yes | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 15, 19 65 to July 15, 19 65 , that (I) (we) last saw the deceased alive on July 15, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE

Dr. Howard Rathbun | | | 23B. DATE SIGNED
July 15, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Howard Rathbun | | | 23D. ADDRESS
4940 Eastern Avenue Baltimore, Maryland #24 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Balto. National Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farkley | | 25C. FUNERAL DIRECTOR ADDRESS
Charles R. Law, 802 Madison Avenue | | | |



65 7431

BALTIMORE CITY HEALTH DEPARTMENT

65 7431

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GILBERT

ANTHONY

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 1965

3:40 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Essex

D. STREET ADDRESS (If rural, give location)

5 Plastic Court

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1-10-1920

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supervisor

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore Transit

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Anthony

14. MOTHER'S MAIDEN NAME

Maggie Shinault

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.11

16. SOCIAL
SECURITY NO.

246-12-7836

17. INFORMANT

ADDRESS

Mrs Opal C. Anthony 5 Plastic Court 20

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-17-1965

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Co.

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Lassahn Funeral Home 7401 Balair Road

ADDRESS

WALLLEY PHOTO

Charles

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|--------------------------------------|--|--|
| BIRTH NO. 65 7432 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7432 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) CONSTANCE C. FAVA | | 2. DATE AND HOUR OF DEATH
JULY 13 - 65 9:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B. COUNTY BALTIMORE Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE CITY TOWSON 6300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
MARYLAND GENERAL HOSPITAL | | D. STREET ADDRESS (If rural, give location)
601 SADLER RD. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) | 8. DATE OF BIRTH
7/29/1890 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
ALABAMA | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
JOSEPH D'ANTONI | | 14. MOTHER'S MAIDEN NAME
VINCENZA VERDEAT CERNIGLIA | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
218-32-3112 | | 17. INFORMANT ADDRESS
ANDREW J. FAVA 7001 BRISTOL RD BALT. MD. | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ACUTE MYOCARDIAL INFARCTION ONE WEEK
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Atherosclerotic Cardiovascular Disease | | CAUSE OF DEATH
(A) ACUTE MYOCARDIAL INFARCTION ONE WEEK
(B) Atherosclerotic Cardiovascular Disease
(C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hepatitis | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>JULY 6</u> 19 <u>65</u> to <u>JULY 13</u> 19 <u>65</u> , that (I) <u>we</u> lost saw the deceased alive on <u>JULY 13</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
N. Michael Gould | | | | 23B. DATE SIGNED
7-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
JULY 16, 1965 | | 24C. NAME OF CEMETERY or CREMATORY
NEW CATHEDRAL CEMETERY | |
| 24D. LOCATION (City, town, county) (State)
BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
John E. Fagan | |
| 25C. FUNERAL DIRECTOR
Wm Cook Brooks | | 25D. ADDRESS
1050 YORK RD TOWSON, TOWSON MD 21204 | | | |

Mississippi
Dances

Hepatitis

3-11-7

X

W. R. R. R. R.

65 7433

BALTIMORE CITY HEALTH DEPARTMENT

65 7433

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GAIL VIRGINIA VOGEL

2. DATE AND HOUR PRONOUNCED DEAD

7/12/65

2:20 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

915 W. Baltimore St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

9/26/1918

9. AGE (in years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life; even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Robert A. Lam

14. MOTHER'S MAIDEN NAME

Grace ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Matter W. Garcia Jr. 3205 St Paul

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)Fatty liver
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1965

Robert E. Farley, M.D.

John J. Cowan & Son, Inc. 901, Hadden's St.
Baltimore, Md.

WALLLEY FORTGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7434 | |
|--|-------------------------|--|--|---|---|
| BIRTH NO. 65 7434
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) CHARLES LOVELL | | | 2. DATE AND HOUR OF DEATH
JULY 14, 1965 1:30 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

St. Joseph's Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3724 Eastwood Drive 21206 | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
July 26, 1908 | 9. AGE (In years lost birthday)
56 yrs. | If Under 1 Yr.
Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fireman | | | 10B. KIND OF BUSINESS OR INDUSTRY
Baker & Whitely Co. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 13. FATHER'S NAME
William Lovell | | |
| 14. MOTHER'S MAIDEN NAME
Anna Bayer | | | 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO.
214-03-2532 | | | 17. INFORMANT
Eleanor Lovell - wife - above | | |
| 18. ADDRESS | | | 19. ADDRESS | | |
| 1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

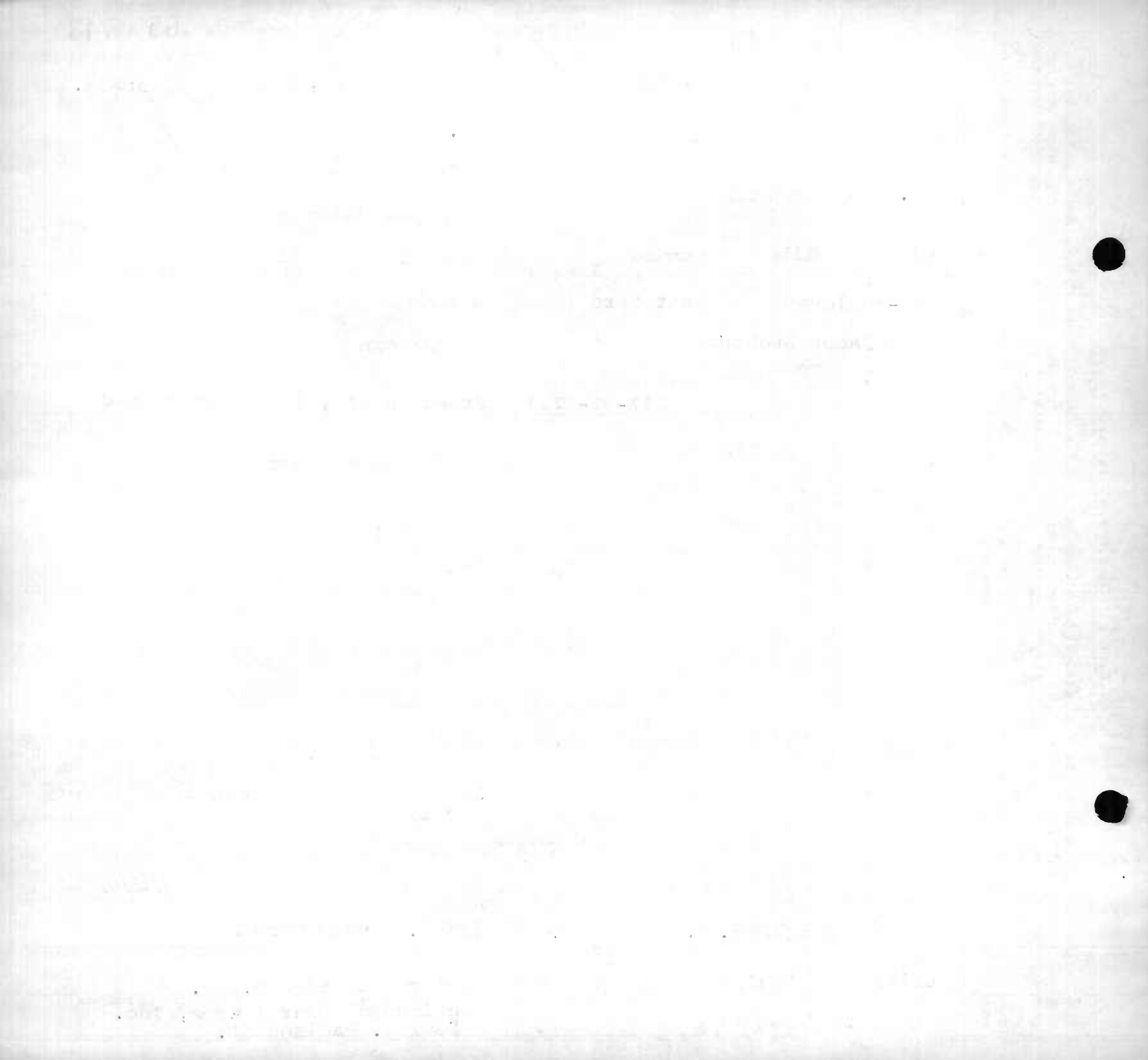
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
Due to Coronary insufficiency
Coronary arteriosclerosis | | |
| INTERVAL BETWEEN ONSET AND DEATH
2 years | | | II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic bronchitis & emphysema | | |
| 19A. DATE OF OPERATION
0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No)
No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 50 to July 14, 19 65, that (I) (we) last saw the deceased alive on June 4, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald Jandorf | | | 23B. DATE SIGNED
7-15-65 | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Donald R. Jandorf | | | 23D. ADDRESS
6077 Harford Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
7/17/65 | | |
| 24C. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | 25B. NAME OF REGISTRAR
Robert E. Farley | | |
| 25C. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane #13 | | | 25D. ADDRESS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|--|--|------------------------|------------------------------------|--|
| BIRTH NO. | | 65 7435 | | CERTIFICATE OF DEATH | | | Registered No. 65 7435 | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | | | |
| | | | | SVOBODA, FRANK | | | | | |
| 2. DATE AND HOUR OF DEATH | | | | July 15, 1965 3:00 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | | | |
| St. Joseph Hospital | | | | Md. Baltr | | | | | |
| 5. SEX | | | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | |
| Male | | White | | Married | | 3/15/83 | | 9. AGE (In years last birthday) 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Self-employed | | | | Boat Yard | | Austria | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| James Svoboda | | | | Unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | 217-32-9721 | | Frank Godack, 1898 Church Road | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Congestive Heart Failme | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 10 19 65 to July 15 19 65, that (I) (we) last saw the deceased alive on July 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | |
| Alphonso Y. S. Rhee | | | | | | | | 7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Alphonso Y. S. Rhee | | | | M.D. 1400 N. Caroline Street | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 7/17/65 | | Holy Redeemer Cemetery | | Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUL 19 1965 | | Robert E. Feltner | | Schimunek Funeral Home, Inc. | | 2601 E. Madison St. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELEANOR RUTH COMI

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 1965 7:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Tennessee

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Nashville

D. STREET ADDRESS (If rural, give location)

4319 Saunders Avenue

5. SEX

Female

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Aug. 20, 1915

9. AGE (in years
lost birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Saleslady

Kain Sloan Dept. Store

11. BIRTHPLACE (State or foreign country)

Tenn.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Walter Richardson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

409-10-4485

17. INFORMANT

ADDRESS

Frank Comi, husbna, d above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.) 21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

7/16/65

23C. NAME of CEMETERY or CREMATORY

Spring Hill Cemetery

23D. LOCATION

(City, town, or county)

Nashville, Tenn.

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION

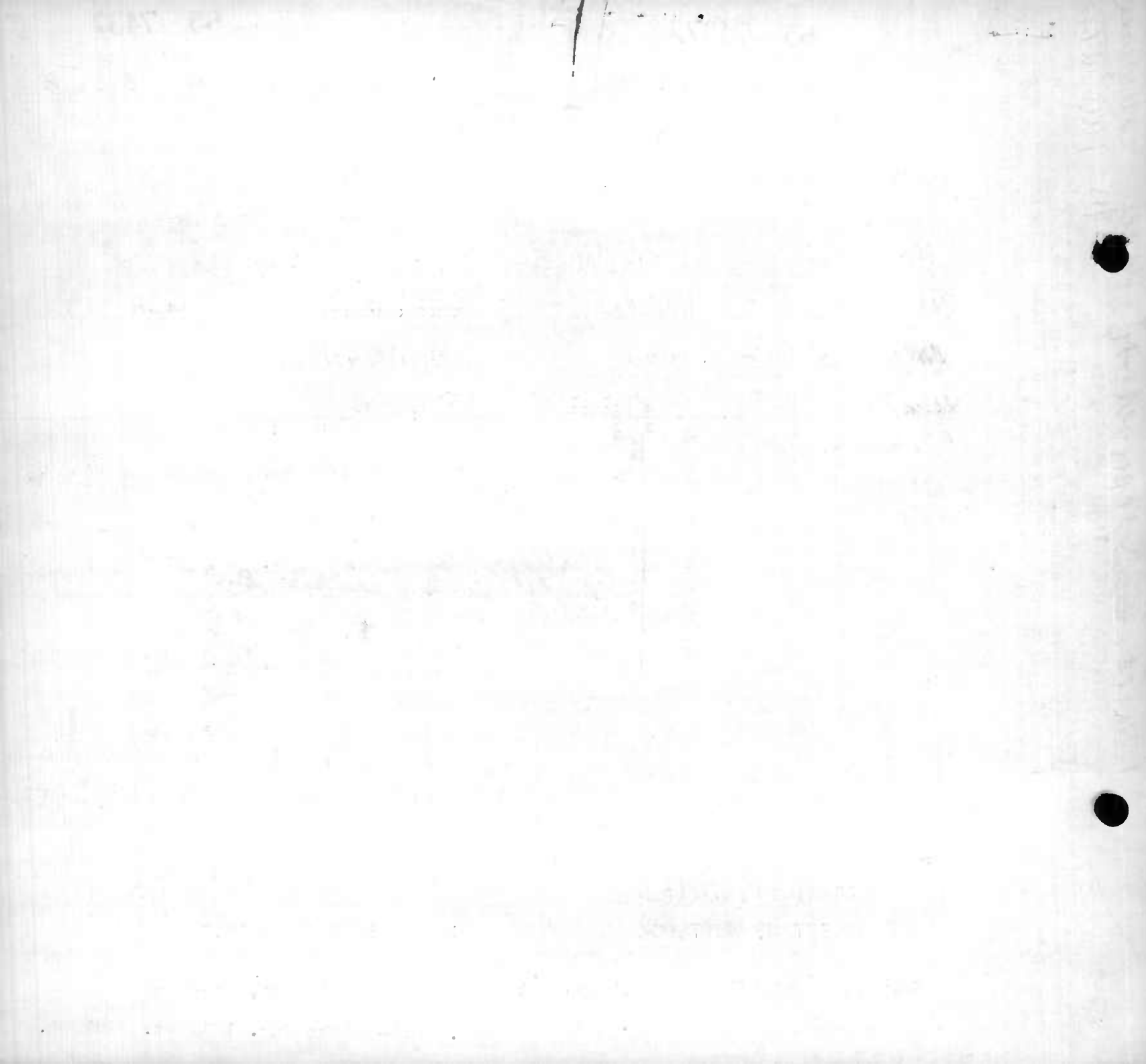
REPORT

ON

ALICE B. BRYAN

1935-1936

Classified



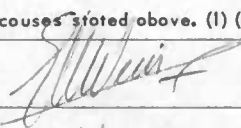
FUNERAL DIRECTOR: IMPORTANT

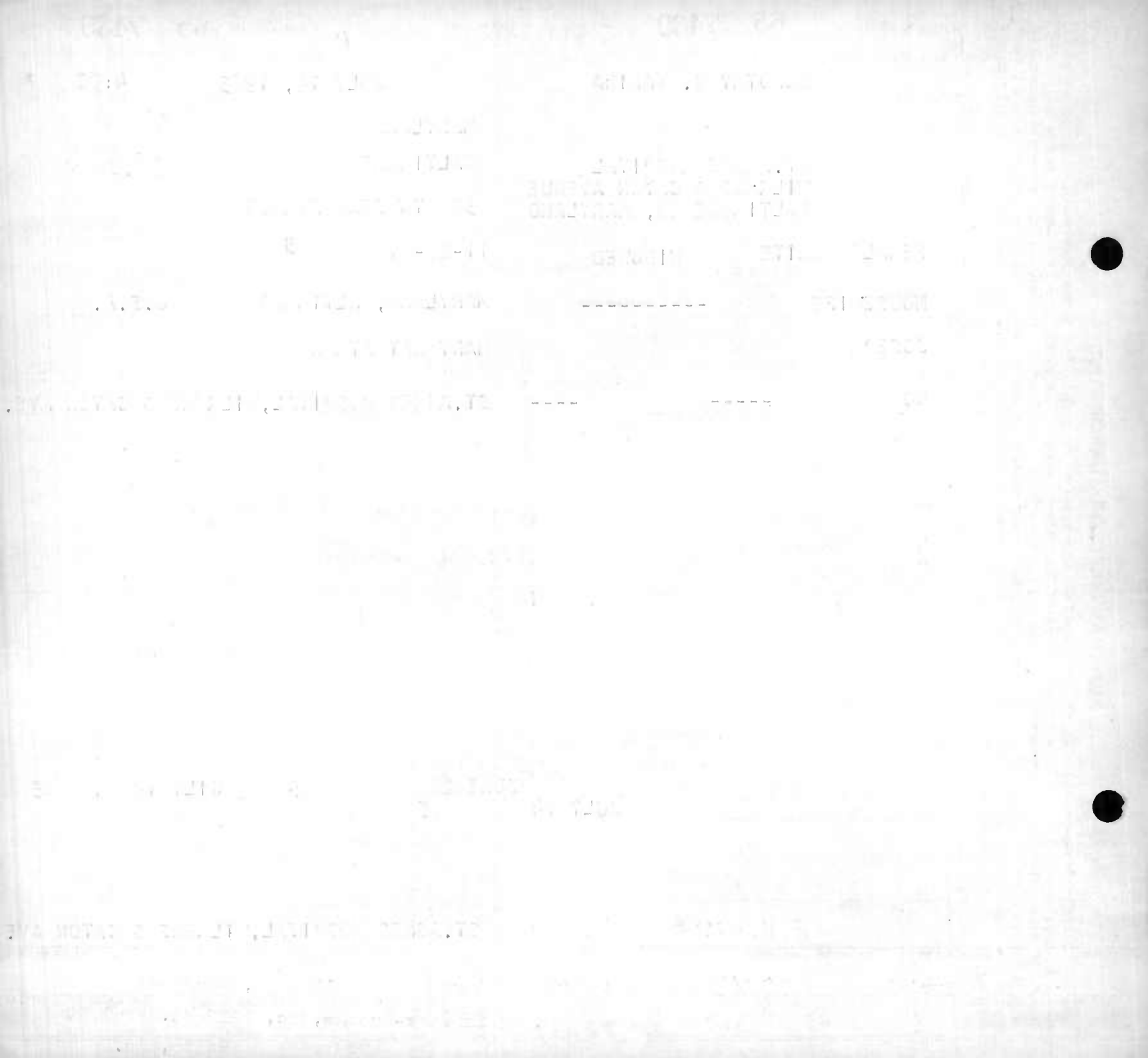
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7438 | |
|---|-------------------------|--|--------------------------------------|--|--|
| BIRTH NO. 65 7438 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
John G. Wedra | | 2. DATE AND HOUR OF DEATH
7-13-65 5:45 A.M. | |
| 1. NAME OF DECEASED
(Type or Print) | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
South Baltimore General Hosp. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 23-01 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore # 21230. | | | |
| | | D. STREET ADDRESS (If rural, give location)
918 So. Charles St. | | | |
| 5. SEX
M. | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
10-4-1907 | 9. AGE (In years last birthday)
57 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY
Minister. | | 11. BIRTHPLACE (State or foreign country)
Baltimore. | |
| 13. FATHER'S NAME
George Wedra. | | 14. MOTHER'S MAIDEN NAME
Kathern Dittman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
yes World War 11 | | 16. SOCIAL SECURITY NO.
212-09-3855 | | 17. INFORMANT ADDRESS
Mr. Joseph A. Wedra 3511 Elmley Ave. 21213 | |
| 18. 003.41
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Sepsis | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
7-1-65 - 7-13-65 | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
7-13-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 7-1-65 to 7-13-65 and that (we) last saw the deceased alive on 7-13-65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Matthew Kaufman | | | | 23B. DATE SIGNED
7-13-65 | |
| 23C. PHYSICIAN'S NAME (Type)
MATTHEW KAUFMAN, M.D. | | | | 23D. ADDRESS
South Balto. Gen. Hosp. - 1213 Light St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | |
| 24D. LOCATION
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. Cook-Brooks Inc. 1217 St. Paul St. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7439 | |
|--|-----------------------------|--|---|--|--|
| BIRTH NO. 65 7439 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DOROTHY G. VARINA | | 2. DATE AND HOUR OF DEATH
JULY 14, 1965 4:00 P. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY AA | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ST. AGNES HOSPITAL
WILKENS & CATON AVENUE
BALTIMORE 29, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
52-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
308 TOWSEND AVENUE | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
11-28-01 | 9. AGE (In years lost birthday)
63 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
MARYLAND, BALTIMORE | |
| 13. FATHER'S NAME
JOSEPH | | | 14. MOTHER'S MAIDEN NAME
MARY NATHATHAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
----- | | 17. INFORMANT ADDRESS
ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH
(A) Cerebrovascular Accident
DUE TO
(B) Arteriosclerotic Cardio Vascular Disease
DUE TO
(C) Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 29 19 65 to JULY 14 19 65 , that (I) (we) last saw the deceased alive on JULY 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-14-65 | |
| 23C. PHYSICIAN'S NAME (Type)
E. H. Weiss | | 23D. ADDRESS
M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7/17/65 | 24C. NAME of CEMETERY or CREMATORY
Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS
Wm Cook-Brooks, Inc, 1217 St. Paul St
Balto, Md. | |



1

65 7440

BALTIMORE CITY HEALTH DEPARTMENT

65 7440

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **CHENNA APPARAO**

2. DATE AND HOUR PRONOUNCED DEAD **7/8/65 3:10 p. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **INDIA**

B. COUNTY **VISHAKHAPATNAM**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) **24-03**

5. SEX **male**

6. RACE **Indian**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH **1920**

9. AGE (In years last birthday) **45**

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **INDIA**

12. CITIZEN OF WHAT COUNTRY? **INDIA**

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **K. A. Graves**

ADDRESS **Munsey Building (2)**

18. **CAUSE OF DEATH**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

Bronchial obstruction

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Acute and chronic bronchitis (asthma?)

(B) DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) **yes**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Rudiger Breiteneker, M.D.**

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **7/9/65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Cremation**

23B. DATE **July 15, 65**

23C. NAME OF CEMETERY or CREMATORY **Greenmount Crematory**

23D. LOCATION (City, town, or county) (State) **Baltimore Maryland**

24A. DATE REC'D BY HEALTH DEPT. **JUL 19 1965**

24B. NAME OF REGISTRAR **R. E. F. F. F.**

24C. FUNERAL DIRECTOR **Wm Cook-Brooks, Inc.**

ADDRESS **1217 St. Paul St.**

VS 151-REV. 1/1/65

WALTER BOND

WALTER BOND

WALTER BOND

WALTER BOND

WALTER BOND

WALTER BOND

WALTER BOND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Certificate of Death | | Registered No. 65 7441 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO.
65 7441 | | M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>KRYSTOFIAR Volin</i> | | 2. DATE AND HOUR OF DEATH
<i>11:45 PM 7/16/65 1145 P.M.</i> | |
| <div style="position: absolute; top: 0; left: 0; font-weight: bold; font-size: 1.2em;">CERTIFICATE CORRECTED 7-20-65</div> 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
(If not in hospital or institution, give street address or location)
<i>Church Home & Hospital</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE <i>Maryland</i> B. COUNTY <i>2-02</i> | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore</i> | | | |
| 5. SEX <i>M</i> | | | | 6. RACE <i>W</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
<i>Widowed</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
<i>1/20/1899</i> | | 9. AGE (In years last birthday) <i>74</i> | |
| 13. FATHER'S NAME
<i>Krystofor Bernar</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Wisniewski Sophie</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>Son. Krystofor Volin</i> | | ADDRESS
<i>618 Belmont Ave</i> | |
| 18. <i>435.01</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH
(A) <i>Atherosclerotic Cardio Vascular Disease</i>
DUE TO
(B) <i>Complete Heart Block</i>
DUE TO
(C) <i>Oedem Stroke Syndrome</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
<i>Venular Fibulation</i> | | | | | | | |
| 19A. DATE OF OPERATION
<input type="radio"/> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/16/65</i> 19 to <i>7/16</i> 1965, that (I) (we) last saw the deceased alive on <i>7/16</i> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>Jose Martinez</i> | | | | | | 23B. DATE SIGNED
<i>7/16/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>JOSE MARTINEZ</i> | | | | 23D. ADDRESS
<i>100 N Broadway 21231</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 24B. DATE
<i>7/20/65</i> | | 24C. NAME OF CEMETERY or CREMATORY
<i>Sacred Heart of Mary Cemetery</i> | | 24D. LOCATION (City, town, or county) (State)
<i>BALTIMORE Co., MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 19 1965</i> | | 25B. NAME OF REGISTRAR
<i>John M. Webber</i> | | 25C. FUNERAL DIRECTOR
<i>JOHN M. WEBBER SONS INC</i> | | | |
| | | | | ADDRESS
<i>461 S. CHESTER ST.</i> | | | |

V.S. 153

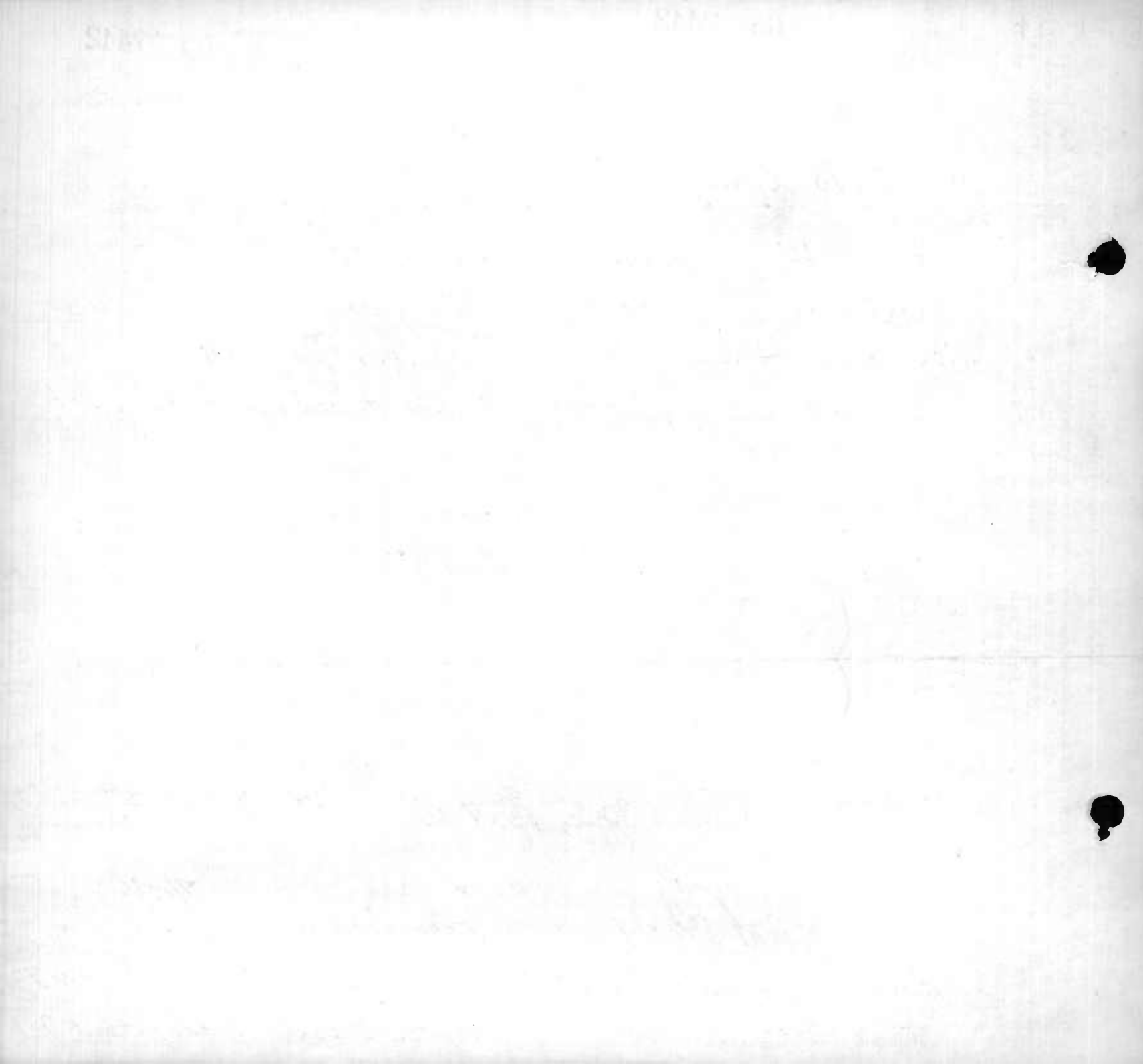
7-20-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7442 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7442 | |
|---|--|--|--|--|--|---------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | Carrie E. ENSOZ | | 7/12/65 30 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 3710 Springdale Ave. | | | | Md. 15-38 | | | |
| 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 8. DATE OF BIRTH Sept. 26, 1878 9. AGE (In years last birthday) 86 | | | | Baltimore | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | D. STREET ADDRESS (If rural, give location) | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Huk | | | | 3710 Springdale Avenue | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Helmer | | | | 14. MOTHER'S MAIDEN NAME Frances Flewble | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Mrs. Charlotte Teilinger, Baltimore Md. | | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | Central nervous system repeated strokes | | | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Uremia | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (B) DUE TO | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 5 th 1965 to July 12 th 1965, that (I) (we) last saw the deceased alive on July 12 th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE M. Paul Byerly | | | | 23B. DATE SIGNED 7/12/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) M. Paul Byerly | | | | 23D. ADDRESS 5820 York Rd Balt 21212 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 7/15/1965 | | | |
| 24C. NAME OF CEMETERY or CREMATORY Hampstead | | | | 24D. LOCATION Hampstead Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farley, Md | | | |
| 25C. FUNERAL DIRECTOR Tipton-Ellis | | | | ADDRESS Hampstead Md. | | | |

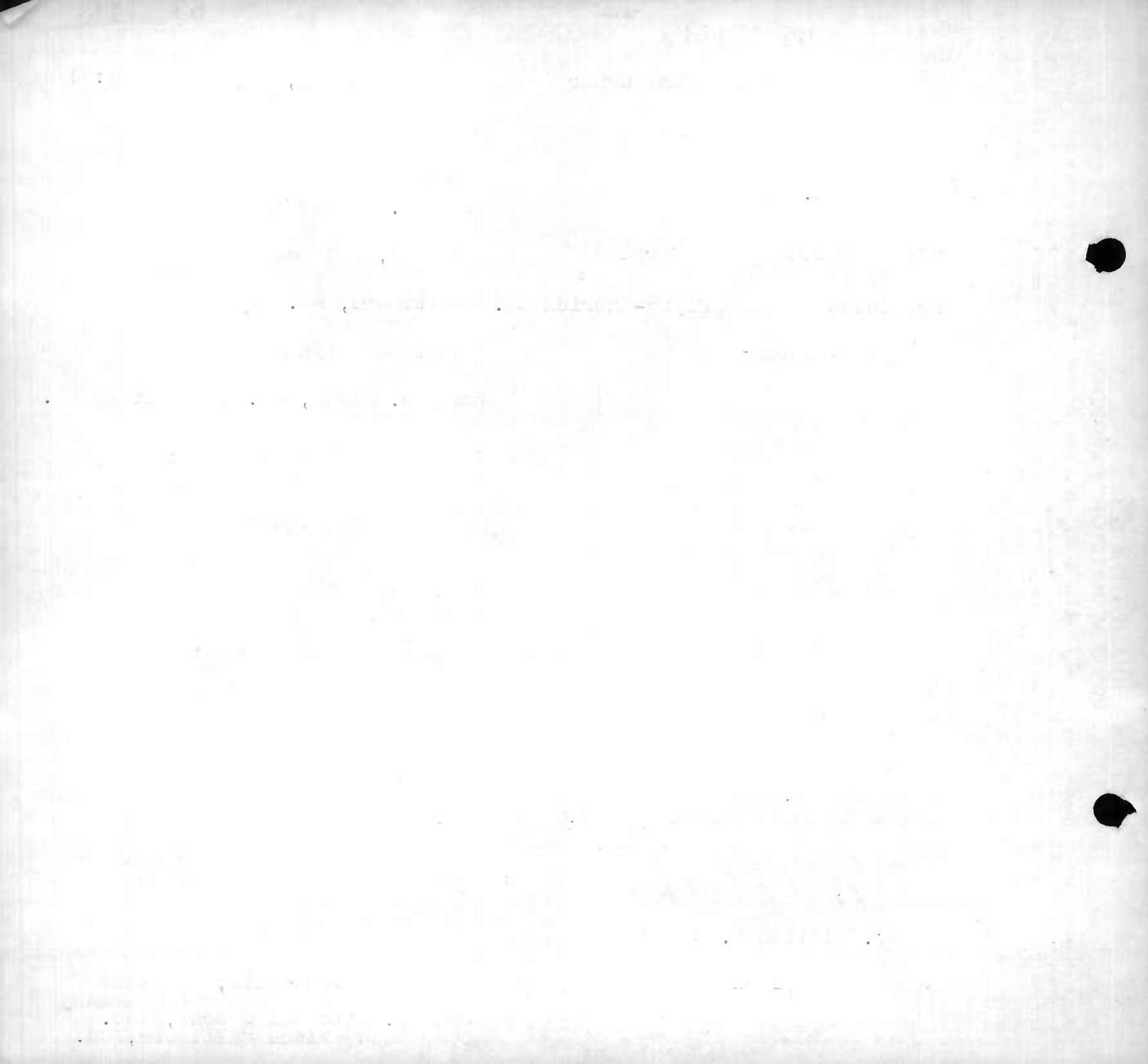


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7443 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7443 | |
|--|-------------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print)
James Flynn Turner | | | | 2. DATE AND HOUR OF DEATH
July 15, 1965 9:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
102 St. Albans Way | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 27-12
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
102 St. Albans Way | | | |
| 5. SEX
Male | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | 8. DATE OF BIRTH
April 17, 1883 | | 9. AGE (In years last birthday)
82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
President | | 10B. KIND OF BUSINESS OR INDUSTRY
Flynn-Emerich Co. | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
Charles Turner | | | | 14. MOTHER'S MAIDEN NAME
Rosiland Flynn | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
James J. Flynn, Jr. 301 Holiday St. | | | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Coronary Occlusion
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Hypertension
Atherosclerosis | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
6-8 hrs
Gradual onset | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1950 to July 15 1965 , that (I) (we) last saw the deceased alive on July 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
W.H. Woody | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7-16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. William H. Woody | | | | 23D. ADDRESS
1403 Park Ave Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-17-65 | | 24C. NAME OF CEMETERY or CREMATORY
Druid Ridge | | 24D. LOCATION (City, town, or county) (State)
Pikesville, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. F... | | 25C. FUNERAL DIRECTOR ADDRESS
John O. Mitchell & Sons, Inc. 1900 Eutaw Place Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|--|---|--|
| BIRTH NO. 65 7444 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 7444 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) EMMA EICHHORD | | | 2. DATE AND HOUR OF DEATH
7/16/65 9:40 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LONG GREEN NURSING HOME
115 E. MELROSE AVE | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location)
242 B RODGERS FORGE RD | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
12.13.82 | 9. AGE (In years lost birthday)
82 | If Under 1 Tr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
HOME | 11. BIRTHPLACE (State or foreign country)
DELAWARE | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
WILLIAM S. LANGFORD | | | 14. MOTHER'S MAIDEN NAME
DOROTHY ROTE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
DOROTHY EICHHORN | | ADDRESS
SAME |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
CORONARY THROMBOSIS
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
CORONARY ARTERIOSCLEROSIS
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
CHRONIC CHOLECYSTITIS | | | INTERVAL BETWEEN ONSET AND DEATH
24 HRS
10 YRS
3 MO. | | |
| 19A. DATE OF OPERATION
7-20-11 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9.18.1959 to 7.16.1965 , that (I) (was) last saw the deceased alive on 7.15.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Paul G. Herold
M.D., Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED
7.16.65 | |
| 23C. PHYSICIAN'S NAME (Type)
PAUL G. HEROLD | | 23D. ADDRESS
M.D. 10 W. MADISON ST 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
7-19-65 | 24C. NAME of CEMETERY or CREMATORY
LOUDON PARK | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
P. G. E. Finkbeiner | | 25C. FUNERAL DIRECTOR ADDRESS
JOHN D. MITCHELL & SONS, INC., 1900 EUTAW PL. BALTO., MD. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7445 | |
|--|--------------|--|---------------------------------------|--|--|
| BIRTH NO. 65 7445 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) NAOMI SCHNEIDER | | 2. DATE AND HOUR OF DEATH
7/15/65 10 45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY BALTIMORE | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
CHURCH HOME + HOSPITAL | | 6. STREET ADDRESS (If rural, give location)
7 WEST BARNEY STREET | | 7. DATE OF BIRTH
11/25/04 | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. AGE (In years last birthday)
60 | 9. AGE (In years last birthday)
60 | 10. AGE (In years last birthday)
60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
BALTO. MD | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Charles Blaney | | 14. MOTHER'S MAIDEN NAME
EMMA HARMAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Pulmonary embolus left lower lobe | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
12 hrs | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO
Carcinoma of ovary with peritoneal metastases | | 12 mos | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
yes | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7.14 19 65 to 7.15 19 65, that (I) (we) last saw the deceased alive on 7.15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Nahum | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7.15.65 | |
| 23C. PHYSICIAN'S NAME (Type)
A. NAHUM | | 23D. ADDRESS
M.D. Church Home & Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7 19 1965 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn | |
| 24D. LOCATION
Balto. Md. | | 24E. NAME OF REGISTRAR
Robert E. Faldut | | 24F. FUNERAL DIRECTOR
Mc Gully | |
| 24G. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 24H. NAME OF REGISTRAR
Robert E. Faldut | | 24I. ADDRESS
130 E. Fort Ave | |

with positive relation
to the presence of
the following
Pyloric and antral
ulcers

CHART

DATA

11/10/17

11/10/17

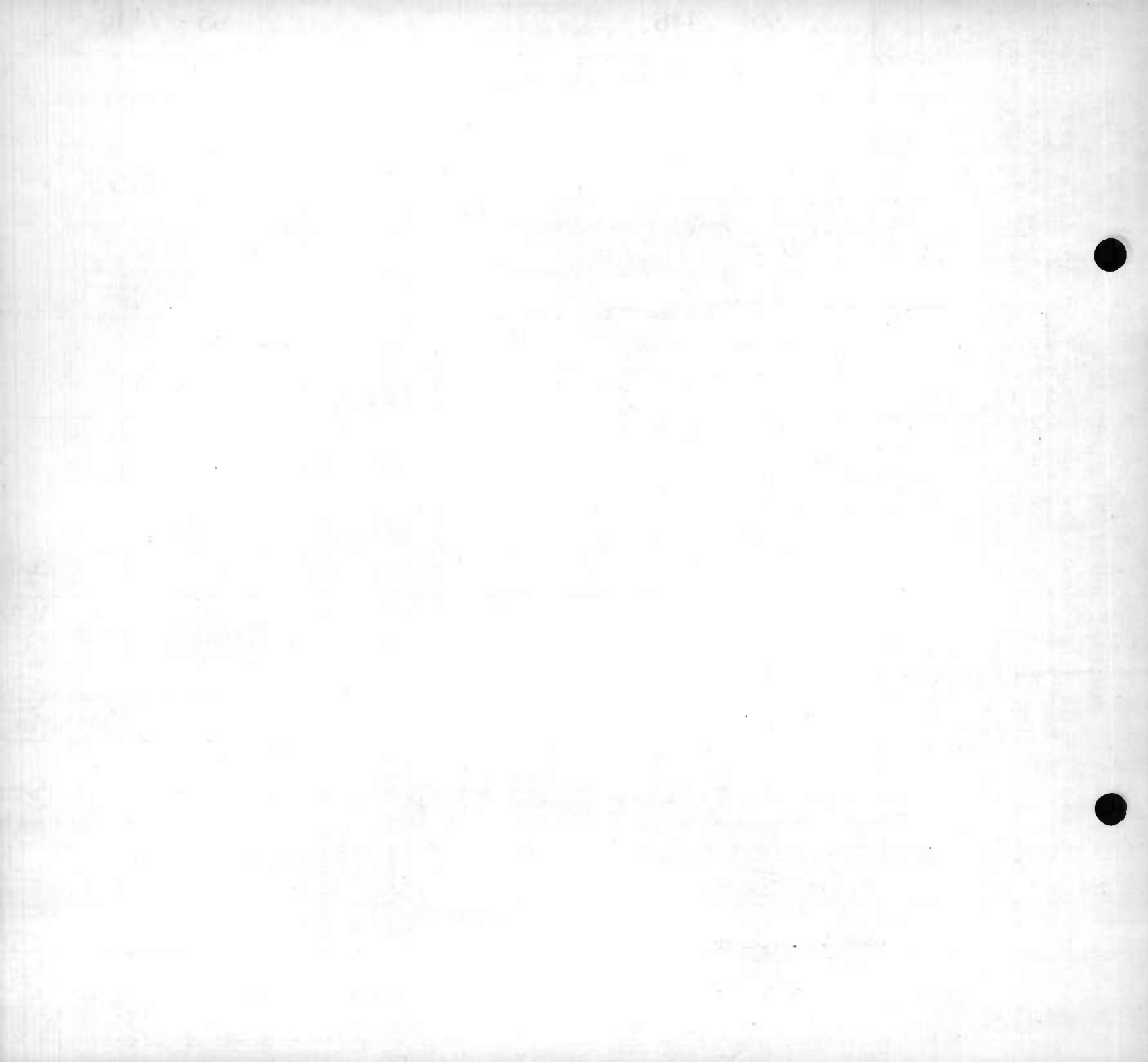
A. HANCOCK
A. HANCOCK

Chief Clerk

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

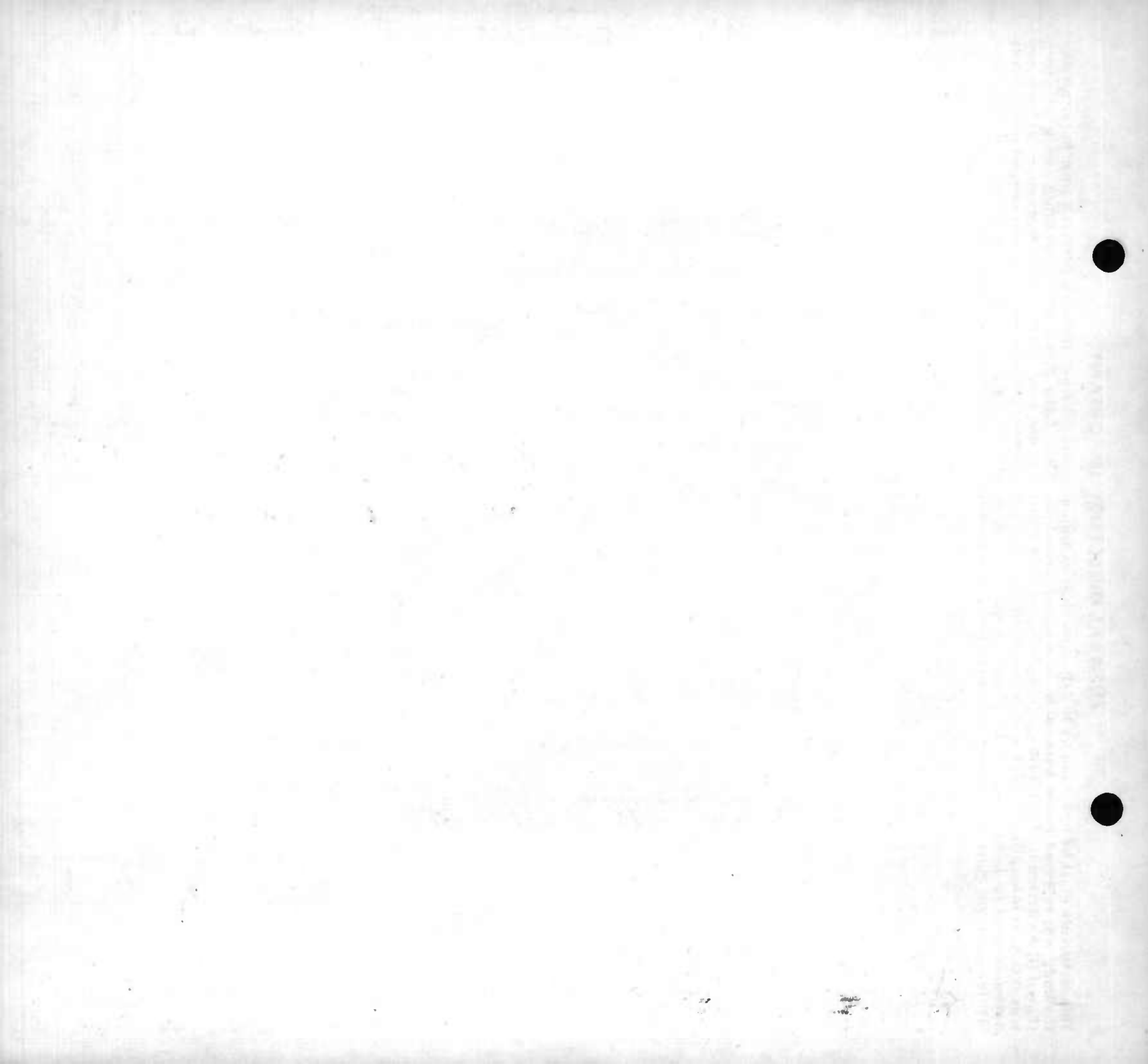
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7446 | |
|---|--------------------------|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <div> <p>65 7446</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>1. NAME OF DECEASED (Type or Print) <u>JOSEPH ELMER HALL, Elmer Joseph</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>7/11/65 6:30 P.M.</u></p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u></p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>Md.</u> B. COUNTY <u>HOWARD</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Savage 63-00</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>100 Commercial St.</u></p> | | |
| 5. SEX <u>Male</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>2/5/13</u> | 9. AGE (In years last birthday) <u>52</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman CHAUFFEUR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>REALTY Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Richard Hall</u> | | | 14. MOTHER'S MAIDEN NAME <u>Blanche GARNER</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u> | | | 16. SOCIAL SECURITY NO. <u>213-01-7733</u> | | 17. INFORMANT <u>R. Stoner, M.D. University Hospital</u> |
| <p>18. I <u>162.1 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | <p>CAUSE OF DEATH</p> <p>(A) <u>Bronchogenic Carcinoma</u></p> <p>DUE TO</p> <p>(B) _____</p> <p>DUE TO</p> <p>(C) _____</p> | | |
| <p>18. I <u>162.1 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | <p>INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u></p> | | |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| <p>22. I certify that (1) (this hospital) attended the deceased from <u>7/7/65</u> 19<u>65</u> to <u>7/11</u> 19<u>65</u>, that (1) (we) last saw the deceased alive on <u>7/11</u> 19<u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p> | | | | | |
| 23A. SIGNATURE <u>Robert E. Stoner, M.D.</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>7/11/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Robert E. Stoner</u> | | | 23D. ADDRESS _____ M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>7-14-65</u> | 24C. NAME of CEMETERY or CREMATORY <u>Savage Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Savage Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 19 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Stoner</u> | | 25C. FUNERAL DIRECTOR <u>Al Witt</u> ADDRESS <u>Donaldson Howard St</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7447 | |
|---|---------------|--|--------------------------------|--|--|
| BIRTH NO. 65 7447 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) IRMA L. DILL | | 2. DATE AND HOUR OF DEATH 16 July 65 5:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | 21-02 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 1232 S. Carey ST #30 | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH April 3, 1881 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Ind. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph Hush | | 14. MOTHER'S MAIDEN NAME Julia Tibbels | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Preston T. Dill - 1232 S. Carey St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO VENTRAL HERNIA W/ IN CARCERATION SHOCK DUE TO (A) | | 11 YRS. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 40 yrs ago | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal operation | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 16 July 65 - 3:30 PM to 16 July 65 - 5:35 PM | | 19 | |
| 23A. SIGNATURE J. M. Rigalito | | 23B. DATE SIGNED 16 July 65 | | 23C. PHYSICIAN'S NAME (Type) J. M. HIPOLITO | |
| 23D. ADDRESS Bon Secours Hosp. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/20/65 | |
| 24C. NAME OF CEMETERY OR CREMATORY Laurel Park Cemetery | | 24D. LOCATION (City, town, or county) Baltimore Md. | | 24E. STATE | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John J. Cowan, Sr., Inc. 901 Hollins St. Balt. 23, Md. | |



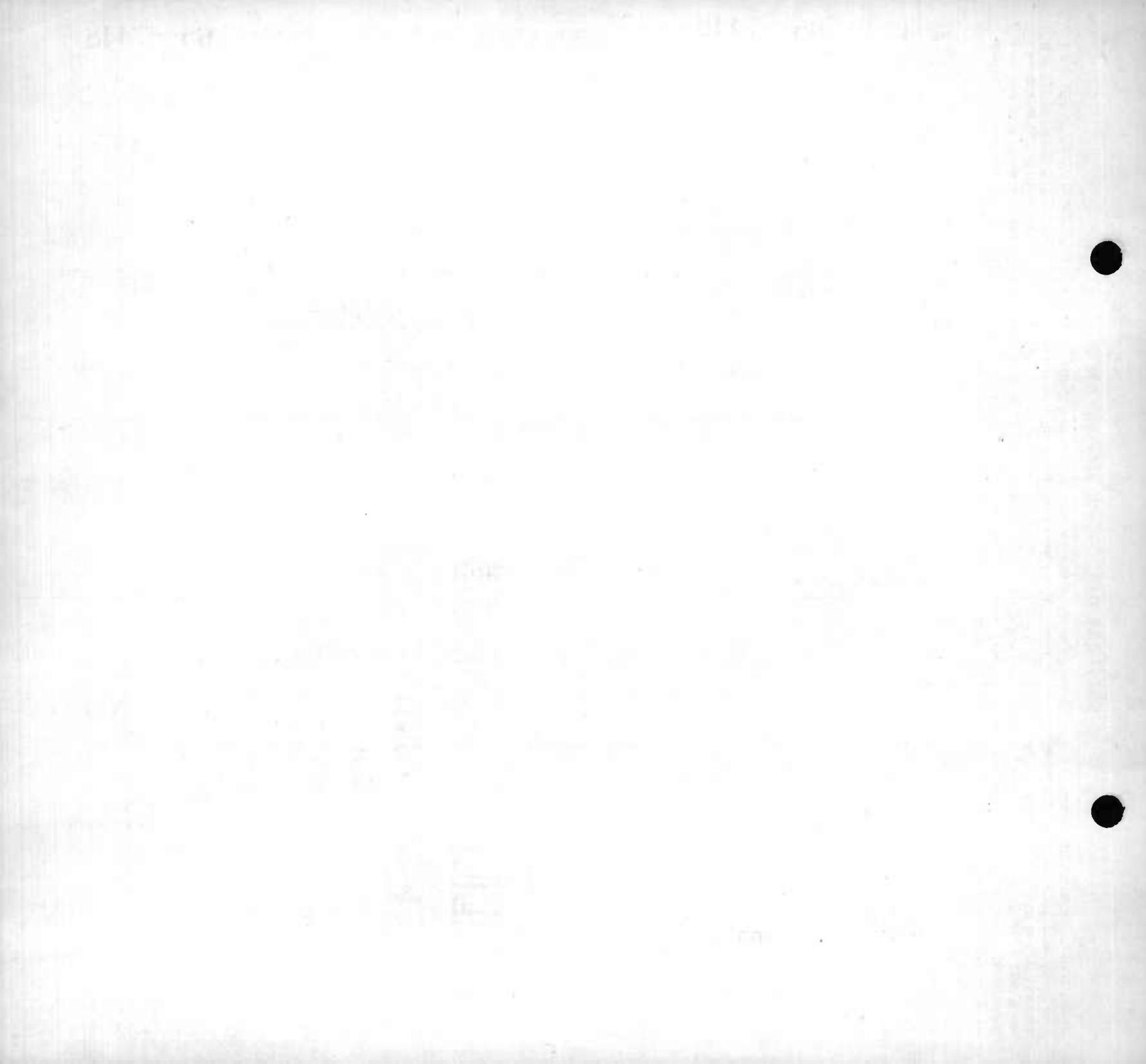
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7448 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7448 | |
|---|---------------------|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) CHESTER STEWART | | | 2. DATE AND HOUR OF DEATH
7-12-65 16:50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University of Maryland Hosp. | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 18-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
106 W Poppleton St | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated | 8. DATE OF BIRTH
7/14/13 | 9. AGE (In years last birthday)
51 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
? | | 10B. KIND OF BUSINESS OR INDUSTRY
? | | 11. BIRTHPLACE (State or foreign country)
7. N.C. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
John Stewart | | |
| 14. MOTHER'S MAIDEN NAME
Sue Court | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
? | | |
| 16. SOCIAL SECURITY NO.
? | | | 17. INFORMANT
Henry A. Saiontz MD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
260X + 3222 | | | CAUSE OF DEATH
(A) DUE TO Diabetes Mellitus
(B) DUE TO Pancreatitis
(C) _____ | | |
| INTERVAL BETWEEN ONSET AND DEATH
1958
1958 | | | 19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Alcoholism | | |
| 19A. DATE OF OPERATION
0 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
0 | | 20A. AUTOPSY? (Yes or No)
0 | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
0 | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
0 | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
0 | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
0 | | 21E. INJURY OCCURRED
White At Work <input type="checkbox"/> 0 Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
0 | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-28-1965 to 7-12-1965 , that (I) (we) last saw the deceased alive on 7-12-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Henry A. Saiontz M.D. | | | 23B. DATE SIGNED
7-12-65 | | 23C. PHYSICIAN'S NAME (Type)
Henry A. Saiontz M.D. |
| 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | |
| 24B. DATE
7/17/65 | | 24C. NAME OF CEMETERY or CREMATORY
ERWIN N.C. | | 24D. LOCATION (City, town, or county) (State)
DUNN, N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farkner | | 25C. FUNERAL DIRECTOR
WM MARLA 928 E. North Ave. | |



43-76-75 IB

65 7449

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 7449

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ben Brown

2. DATE AND HOUR OF DEATH

7-14-65

4:30

P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2107 Sinclair Lane - #21213

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

11-90-00

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WALTER BROWN

14. MOTHER'S MAIDEN NAME

BLANCHE LANE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue-21224

18. I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchogenic Carcinoma

2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-3 19 65 to 7-14 19 65,
that (I) (we) last saw the deceased alive on 7-14 19 65 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Rathbun

M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-14-65

23C. PHYSICIAN'S
NAME (Type)

Dr. H. Rathbun

M.D.

4940 Eastern Avenue - #21224

24A. BURIAL CREMATION
REMOVAL (Specify)

BURIAL

24B. DATE

7/19/65

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION

(City, town, or county)

A. D. County, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1965

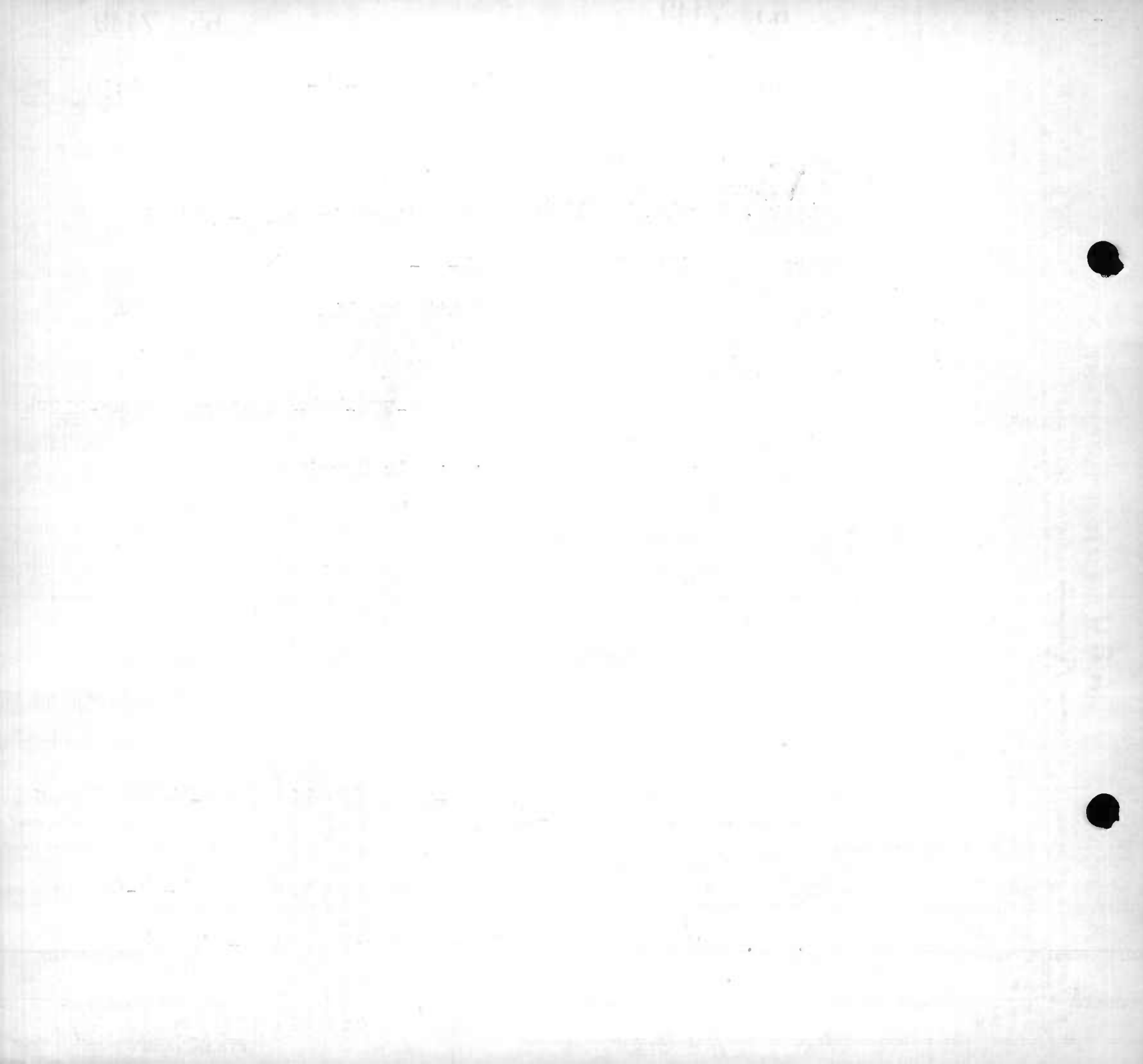
Robert E. Taylor, Jr.

Joseph G. Locks, Jr. 1304 N. Charles St.

VS 150 REV. 12-1-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



1

65 7450

BALTIMORE CITY HEALTH DEPARTMENT

65 7450

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHAEL

GAYDOS

2. DATE AND HOUR PRONOUNCED DEAD

June 29, 1965

7:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

4-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

113 N. Paca Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

4-4-15

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ST CLAIR PA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNK

14. MOTHER'S MAIDEN NAME

UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

174-01-2471

17. INFORMANT

ADDRESS

HELEN NEULAN 113 N PACA ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/29/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-16-65

23C. NAME OF CEMETERY or CREMATORY

BALTO NAT CEM

23D. LOCATION

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

24B. NAME OF REGISTRAR

Robert E. F. [Signature]

24C. FUNERAL DIRECTOR

Paul E. [Signature]

ADDRESS

20 21-4-4
ST CLARK PA
NEW

NEW

2-18-45 PATENT COM
PAID

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7451

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

W.

MORGAN

2. DATE AND HOUR PRONOUNCED DEAD

July 14, 1965

5:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Jail

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

708 S. Bond Street

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

4-21-1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

MR. GEORGE W. MORGAN SR.

14. MOTHER'S MAIDEN NAME

VICTORIA COOK MORGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

MR. GEORGE W. MORGAN SR.

ADDRESS

STAR ROUTE

VANCEVILLE, N.C.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/14/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7-16-65

23C. NAME of CEMETERY or CREMATORY

PLEASANT GROVE PRES

23D. LOCATION

(City, town, or county)

(State)

VANCEVILLE

NORTH CAROLINA

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

24B. NAME OF REGISTRAR

Paul E. Farley, M.D.

24C. FUNERAL DIRECTOR

Paul E. Knowlton, Jr. 3615 Chestnut Ave

RECEIVED

4-11-77

WILL CAROLINA

STREET

VICTORIA COOL WORKS
GEORGE W. WORKMAN

AL FROST W. WORKMAN

1952

RECEIVED 7-11-82
WILL CAROLINA

FUNERAL DIRECTOR: IMPORTANT

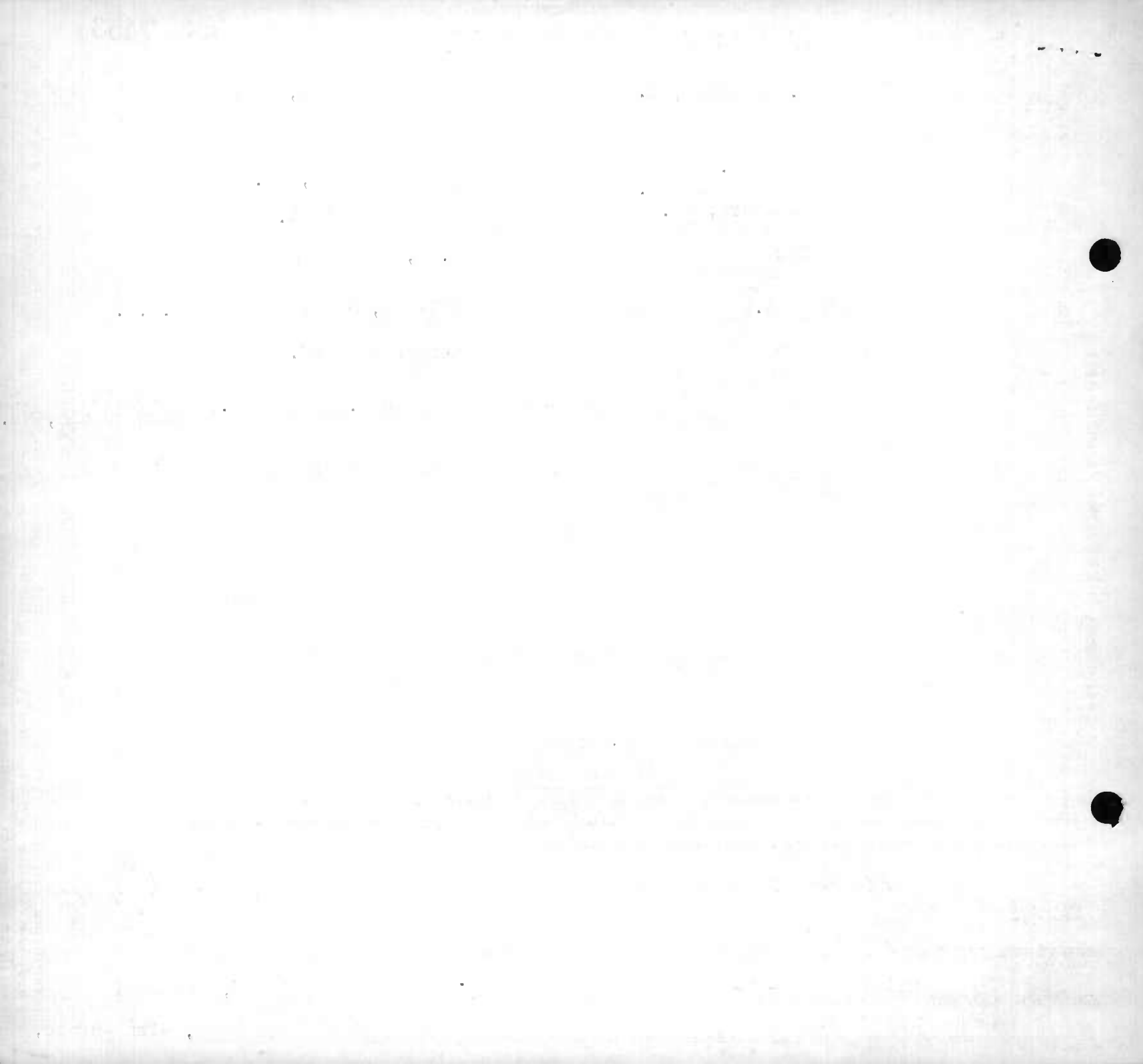
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 65 7452 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7452 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) <i>PHILLIP TAGLIAVIA - Tagliana</i> | | | 2. DATE AND HOUR OF DEATH
<i>7/16/65 2:00AM</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>UNIVERSITY OF MARYLAND HOSPITAL</i> | | | A. STATE <i>MARYLAND</i>
B. COUNTY <i>4-02</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>BALTIMORE</i> | | |
| | | | D. STREET ADDRESS (If rural, give location)
<i>511 W LEXINGTON STREET</i> | | |
| 5. SEX
<i>M</i> | 6. RACE
<i>W</i> | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
<i>Widow</i> | 8. DATE OF BIRTH
<i>5/19/75</i> | 9. AGE (In years last birthday)
<i>90</i> | If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>CONSTRUCTION</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY?
<i>ITALIAN</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>ITALY</i> | | 14. MOTHER'S MAIDEN NAME
<i>?</i> | | | |
| 13. FATHER'S NAME
<i>Emmanuel Tagliavia</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>NO</i> | | | |
| 16. SOCIAL SECURITY NO.
<i>219909018</i> | | 17. INFORMANT
<i>DAUGHTER</i> | | | |
| 18. <i>1992 I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<i>DISSEMINATED CARCINOMA</i> | | CAUSE OF DEATH
(A) <i>DISSEMINATED CARCINOMA</i>
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>? < 1 year</i> | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>2 NOW</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
<i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<i>yes</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/10</i> 19 <i>65</i> to <i>7/16</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>7/16</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Fred N. Sugar, M.D.</i> | | | | 23B. DATE SIGNED
<i>7/16/65</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>Fred N. Sugar</i> | | | | 23D. ADDRESS
<i>UNIVERSITY HOSPITAL, BALTO., MD.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7-21-65</i> | | 24C. NAME of CEMETERY or CREMATORY
<i>New Catholic</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 19 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR
<i>Walter Dabrowski, 1005 Dundalk Ave.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7453 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7453 | |
|--|--|---|--|--|--|---|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) IRVIN T. HOWARD Jr. | | | | July 14, 1965 4:35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mount Conv. Home
3706 Nortonia Rd.
Baltimore, Md. | | | | A. STATE Maryland
B. COUNTY 21-02 | | | |
| 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | 8. DATE OF BIRTH Dec. 7, 1882 | | 9. AGE (in years lost birthday) 82 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Watchman (Ret.) | | 10B. KIND OF BUSINESS OR INDUSTRY
Trucking | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas Howard | | | | 14. MOTHER'S MAIDEN NAME
Margaret Ward. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-03-0135 | | 17. INFORMANT
Irvin T. Howard Jr., | | ADDRESS
Ferndale, Glen Burnie, Md. | |
| 18. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic heart disease
DUE TO
3 years | | | | CAUSE OF DEATH
(A) Arteriosclerotic heart disease
(B)
(C)
INTERVAL BETWEEN ONSET AND DEATH | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 2, 1962 to July 14, 1965 , that (I) (we) last saw the deceased alive on July 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Abraham B. Hurwitz | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
July 15, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
ABRAHAM B. HURWITZ | | | | 23D. ADDRESS
7501 LIBERTY ROAD, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-17-65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore Cemetery | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
P. V. Singleton | | ADDRESS
Singleton Funeral Home, Glen Burnie, MD. | |



BIRTH NO. 65

7454

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65

7454

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DANIEL

C.

EDLER

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 1965

1:20 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

109 S. Monroe Street

5. SEX

Male

6. RACE

White
Caucasian7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 29, 1916

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waiter

10B. KIND OF BUSINESS OR INDUSTRY

Colonial House

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

-----Edler

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. (If yes, give war or dates of service))16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Balto. 23, Md.
Mrs. Margaret A. Edler, 109 S. Monroe St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK☐NOT WHILE
AT WORK☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/19/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore 29, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1965

Robert E. Farley

Witzke F.D. 4101 Edmondson Ave

WALTON

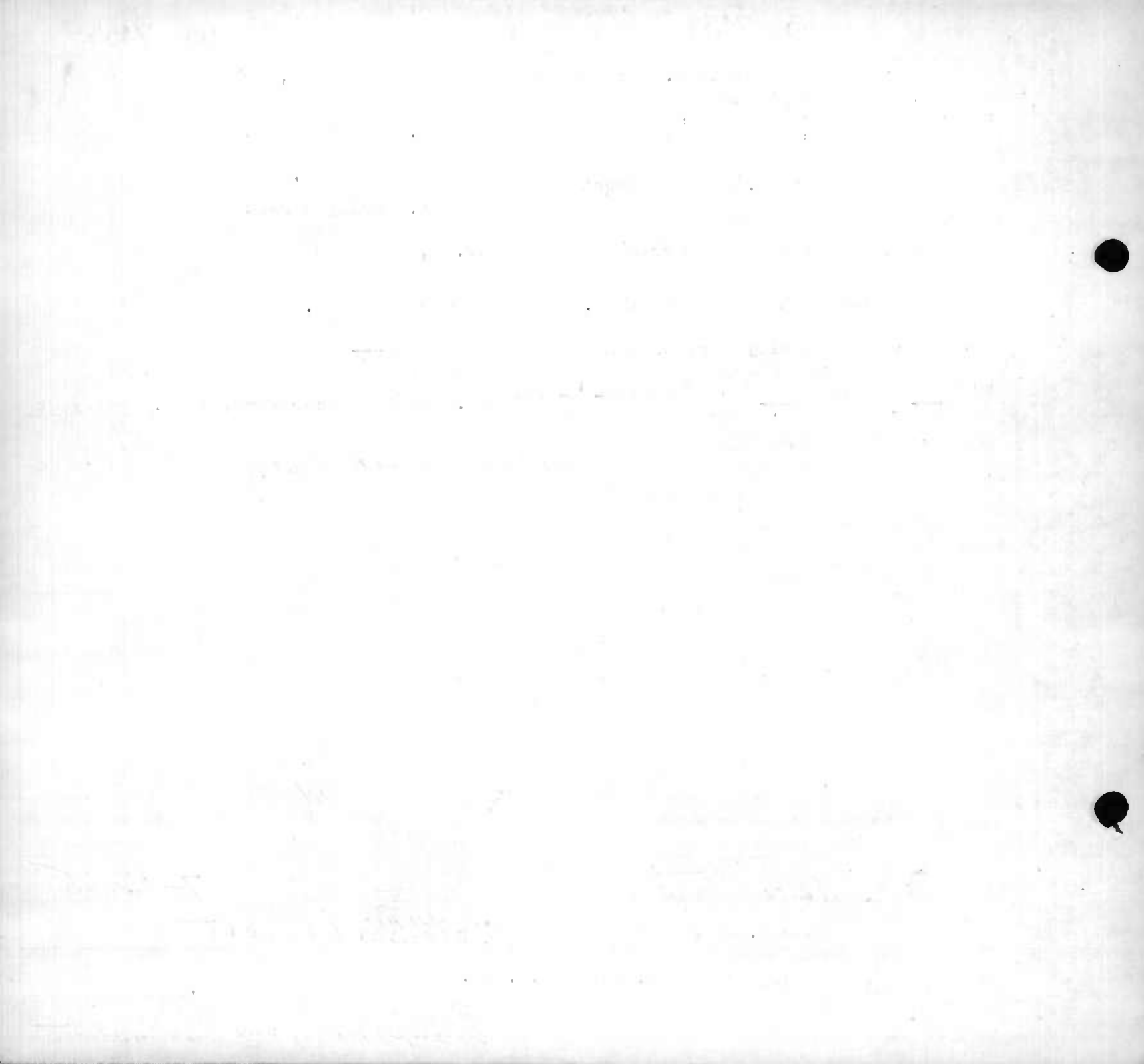
1900

WALTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

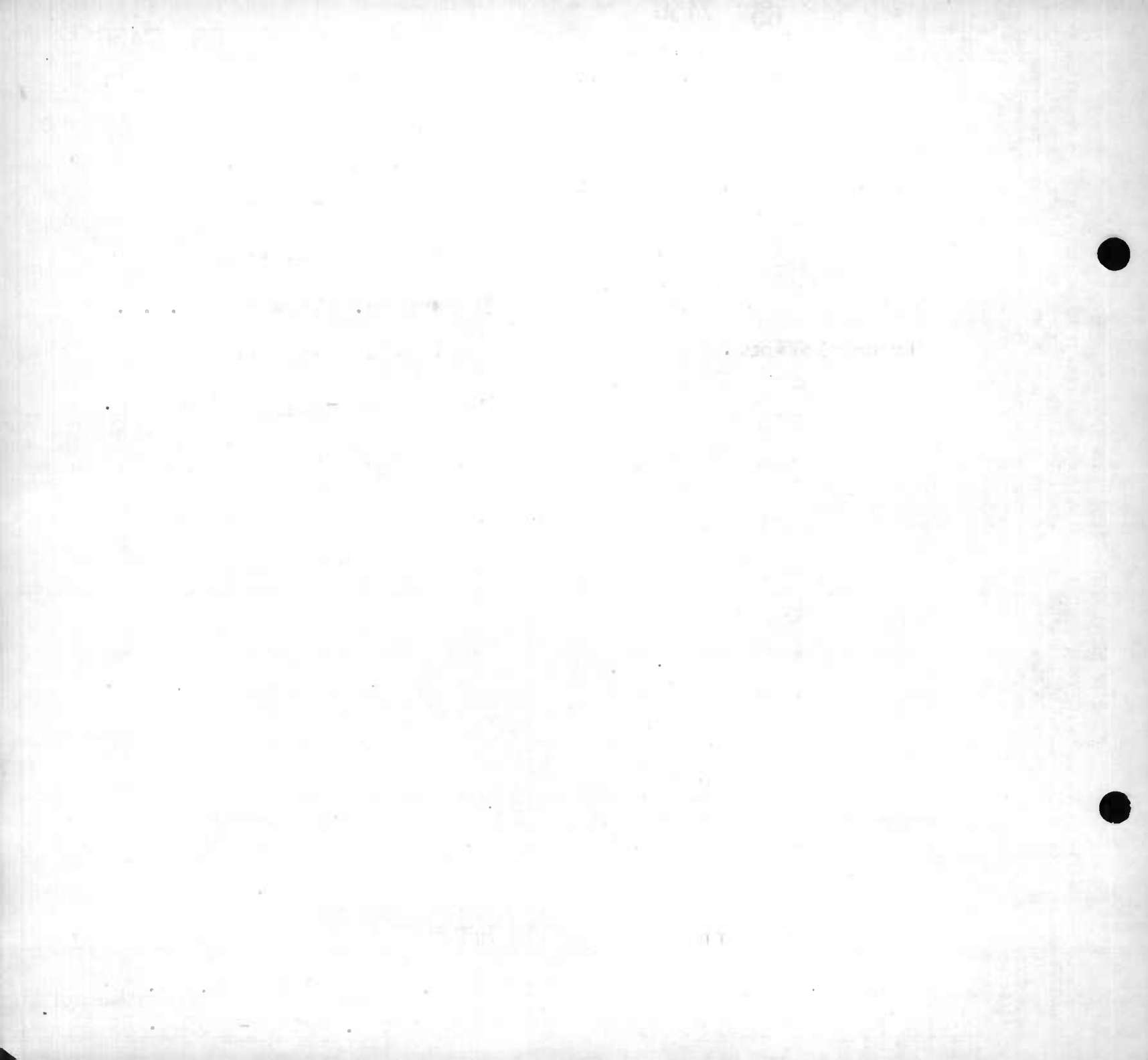
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|------------------|--|--|--|---|--|--|--|--|--|
| BIRTH NO. 65 7455 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 7455 | | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED
(Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| | | | | | Lottie E. Macarevich | | | | | July 16, 1965 | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | | | | | A. STATE B. COUNTY | | | | | |
| 519 N. Curley Street | | | | | | | | | | 519 N. Curley Street | | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | | | | | | | Baltimore Md. | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | | | | | | | 519 N. Curley Street | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | 10. Under 1 Yr. Months | | 11. Under 24 Hrs. Days Hours Min. | | | |
| Female | | White | | WIDOWED, DIVORCED (specify)
Married | | Nov. 23, 1909 | | 55 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Saleslady | | | | Hecht Co. | | | | Freeland Pa. | | | | | | | |
| 13. FATHER'S NAME | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Stanley Bartosevich | | | | | | | | Mary--- | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | |
| --- | | | | 165-01-9771 | | | | Mr. Stanley Macarevich, 519 N. Curley St | | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | (A) <i>carcinoma lung</i> | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | DUE TO | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (B) _____ | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | DUE TO | | | | | |
| (C) _____ | | | | | | | | | | | | | | | |
| II | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| Sept 1964 | | | | carcinoma lung | | | | no | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 1964 to 1964, that (I) (we) last saw the deceased alive on 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | 23B. DATE SIGNED | | | | | | | |
| <i>Otto C. Brantigan</i> | | | | | | | | 7-16-65 | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | 23D. ADDRESS | | | | | | | |
| Otto C. Brantigan | | | | | | | | 104 W. Madison St | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Removal | | | | July 16/65 | | | | St. Johns R.C. Cem. | | | | Freeland Pa. | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| JUL 19 1965 | | | | Robert E. Taylor | | | | Philip Herwigton | | | | 2024 Williams St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

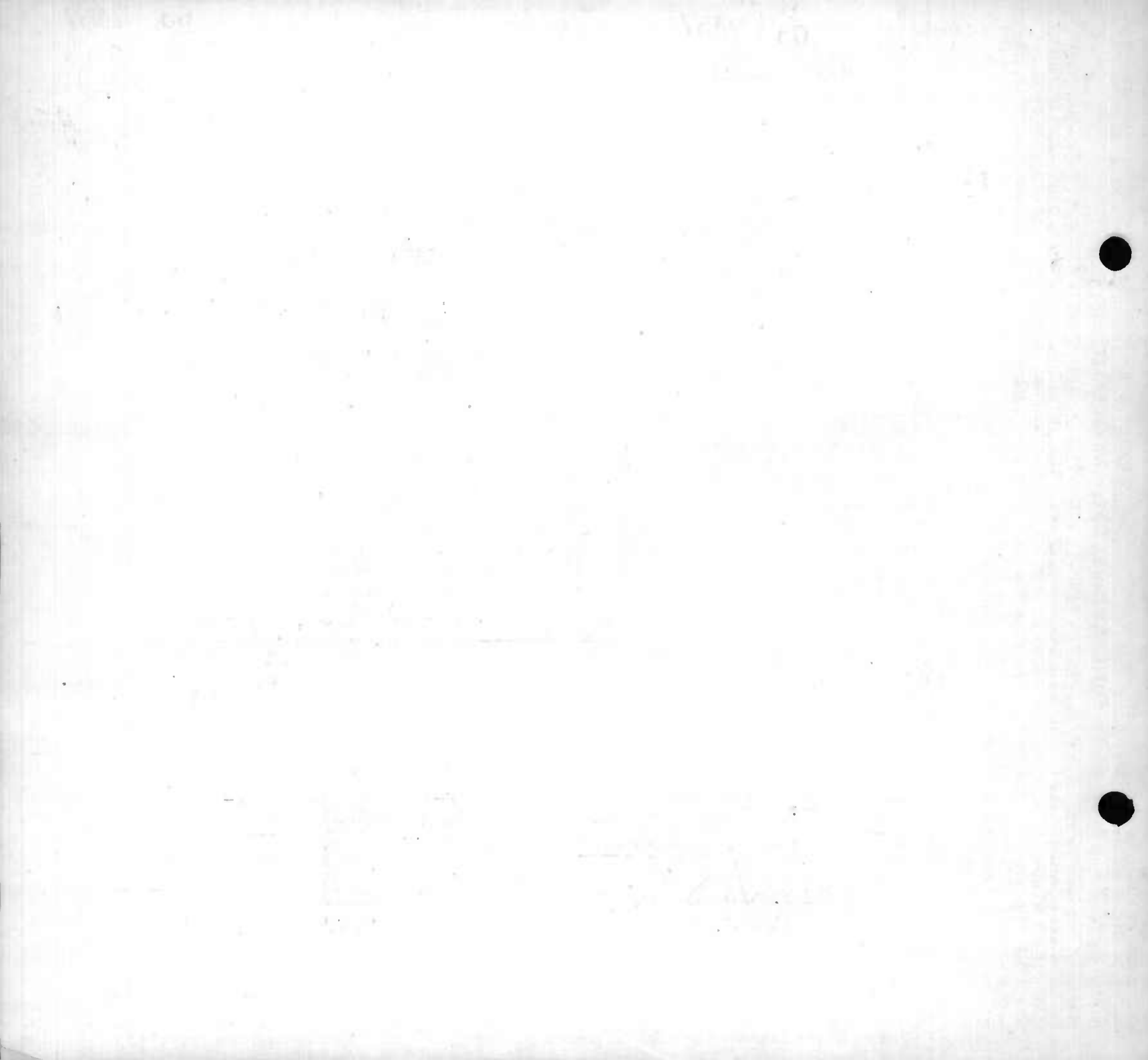
| | | | | | |
|---|-------------------------|---|-----------------------------------|---|---|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7456 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) DIONNE F. BAGGETT | | 2. DATE AND HOUR OF DEATH
7-12-65 8:05P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 13-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION
THE JOHNS HOPKINS H. SPITAL | | D. STREET ADDRESS (If rural, give location)
2526 MADISON AVENUE | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
CHILD | 8. DATE OF BIRTH
1-9-64 | 9. AGE (In years last birthday)
ONE YEAR | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
El Paso Co. Colorado | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Vernon Penner | | 14. MOTHER'S MAIDEN NAME
YVETTE M BAGGETT | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Inez Baggett-2526 Madison Ave. | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cyanotic Apneic Spell | | CAUSE OF DEATH
(A) DUE TO
Congnital Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
Present at Birth | |
| II. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from July 7, 1965 to July 12, 1965 , that (I) (he) lost saw the deceased alive on July 12, 1965 and that (in my) (her) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Tom Austin | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-12-65 | |
| 23C. PHYSICIAN'S NAME (Type)
TOM AUSTIN | | 23D. ADDRESS
Apt. #904 550 N. Broadway | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/15/65 | | 24C. NAME of CEMETERY or CREMATORY
Arbutus Memorial Pk. | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Herbert E. Farkner | |
| 25C. FUNERAL DIRECTOR
Herbert E. Nutter-3035 W. North Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7457 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7457 | |
|---|------------------|---|-------------------------------|--|--|---|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Enzya Powell | | 2. DATE AND HOUR OF DEATH
7/12/65. 7:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE MARYLAND B. COUNTY 15-47 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
THE JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2952 CLIFTON AVE. | | | |
| 5. SEX
FEMALE | 6. RACE
NEGRO | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
9/16/1930 | 9. AGE (In years last birthday)
34 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Waitress | | 10B. KIND OF BUSINESS OR INDUSTRY
Resturant | | 11. BIRTHPLACE (State or foreign country)
Nelson Co. Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WALTER JOHNSON | | | | 14. MOTHER'S MAIDEN NAME
HALEY Mae Johnson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
BY M.D. | | 17. INFORMANT ADDRESS
Mr. Henry D. Powell 2952 Clifton Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)
E933X
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Had been taking Trilifon, dose recently increased. This not ruled out as cause of death. | | | | CAUSE OF DEATH
Toxic Hepatitis and Nephritis, Infectious Hepatitis
Toxin unspecified | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input checked="" type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Unknown | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Unknown 00-00 | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)
Unknown | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
Unknown | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-10 1965 to 7-12 1965, that (I) (we) lost saw the deceased alive on 7-12 1965 and that in (my) (66) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Lee J. Silver | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7-12-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Lee J. Silver | | | | 23D. ADDRESS
M.D. Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/16/65 | | 24C. NAME of CEMETERY or CREMATORY
BALTIMORE NATL. CEM | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS
Herbert E. Nutter 3035 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 65 7458 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7458 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) <u>Raymond Barnes</u> | | | July 14, 1965 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| HOSPITAL OR INSTITUTION
<u>Lutheran Hospital of Md.</u> | | | A. STATE <u>Maryland</u> | | |
| | | | B. COUNTY <u>Baltimore</u> | | |
| 5. SEX <u>Male</u> | | | 6. RACE <u>Colored</u> | | |
| 7. MARRIED, NEVER MARRIED
<u>Married</u> | | | 8. DATE OF BIRTH <u>7/15/1911</u> | | |
| 9. AGE (In years last birthday) <u>55</u> | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>Snow Hill N.C.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>William Barnes</u> | | | 14. MOTHER'S MAIDEN NAME <u>Lula Joyner</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <u>244-12-2395</u> | | |
| 17. INFORMANT <u>Novella Barnes</u> | | | ADDRESS <u>1007 St Poplar Grove</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
<u>Myocardial Infarction</u> | | | CAUSE OF DEATH
(A) DUE TO <u>Myocardial Infarction</u> | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/14/65</u> 19 to <u>7/18/65</u> 19, that (I) (we) lost saw the deceased alive on <u>7/14/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W. Garner</u> | | | 23B. DATE SIGNED <u>7/15/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>WM GARNER M.D.</u> | | | 23D. ADDRESS <u>1005 W. Longfellow Ave.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>7/18/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Family Lot</u> | |
| 24D. LOCATION <u>Wilson North Carolina</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>JUL 19 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter-3035 W. North</u> | | | |

V.S. 153

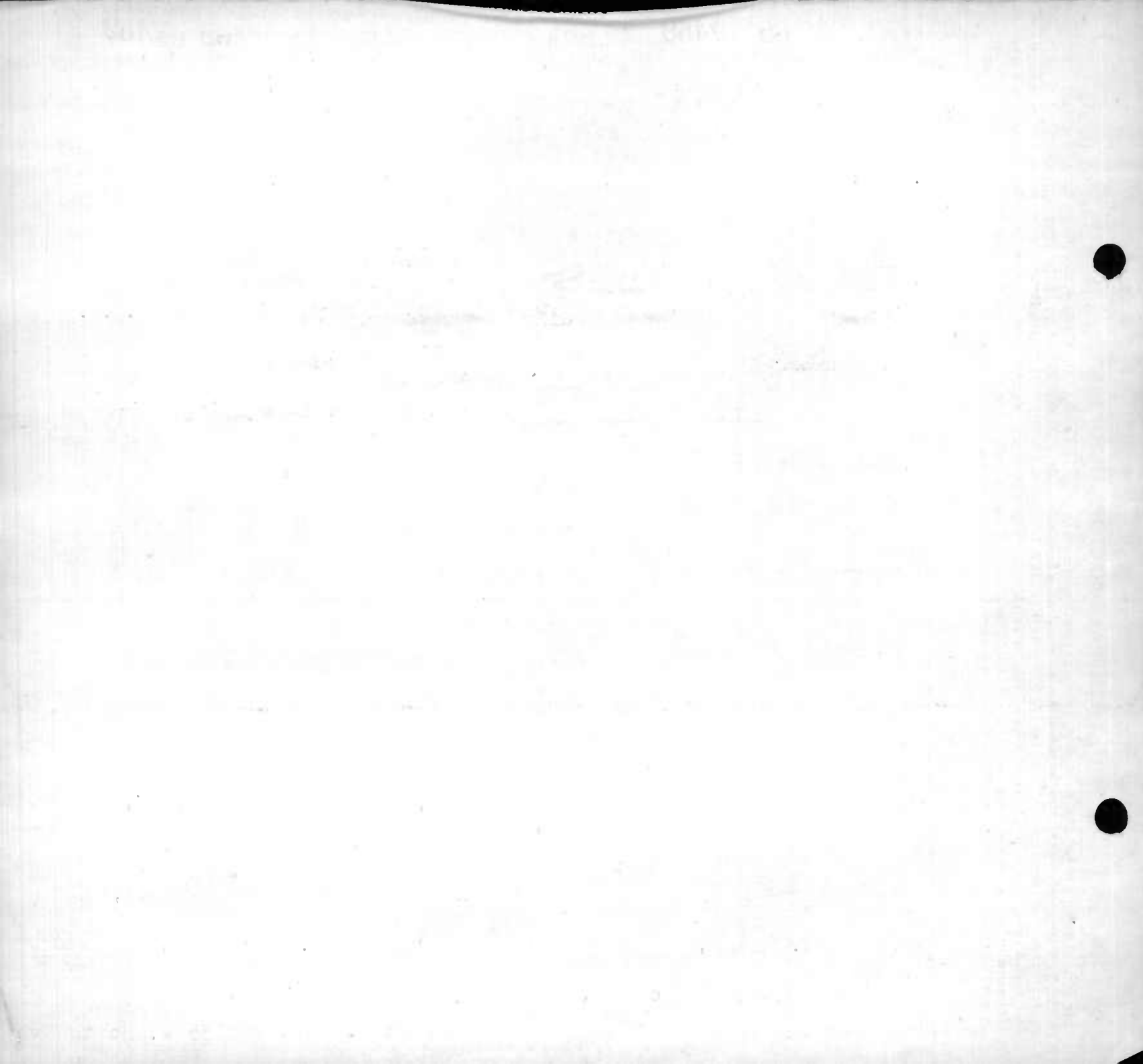
7-23-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 7459 | |
|---|---------------|--|--|---|---|
| BIRTH NO. 65 7459 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Carrie Webb | | | 2. DATE AND HOUR OF DEATH July 13, 1965 11:25 p.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | | A. STATE Maryland B. COUNTY 16-01 | | |
| C. CITY OR TOWN Baltimore | | | D. STREET ADDRESS (If rural, give location) 1102 Lafayette Avenue | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH Jan 1, 1898 | 9. AGE (In years last birthday) 67 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid | | 10B. KIND OF BUSINESS OR INDUSTRY Private Family | 11. BIRTHPLACE (State or foreign country) Talbot County, Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Henry Thomas | | | 14. MOTHER'S MAIDEN NAME Ella ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Gertrude Peterson | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH (A) Diabetic Coma (B) DUE TO (C) | | |
| 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) yes | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED White At Work Not White At Work | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 11, 19 65 to July 13, 19 65, that (I) (we) last saw the deceased alive on July 13, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. Rigvad, | | | 23B. DATE SIGNED July 14, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) A. Rigvad, | | | 23D. ADDRESS M.D. 1514 Division St. Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/17/65 | 24C. NAME of CEMETERY or CREMATORY Mount Auburn CEM. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 3035 W. North Ave | |

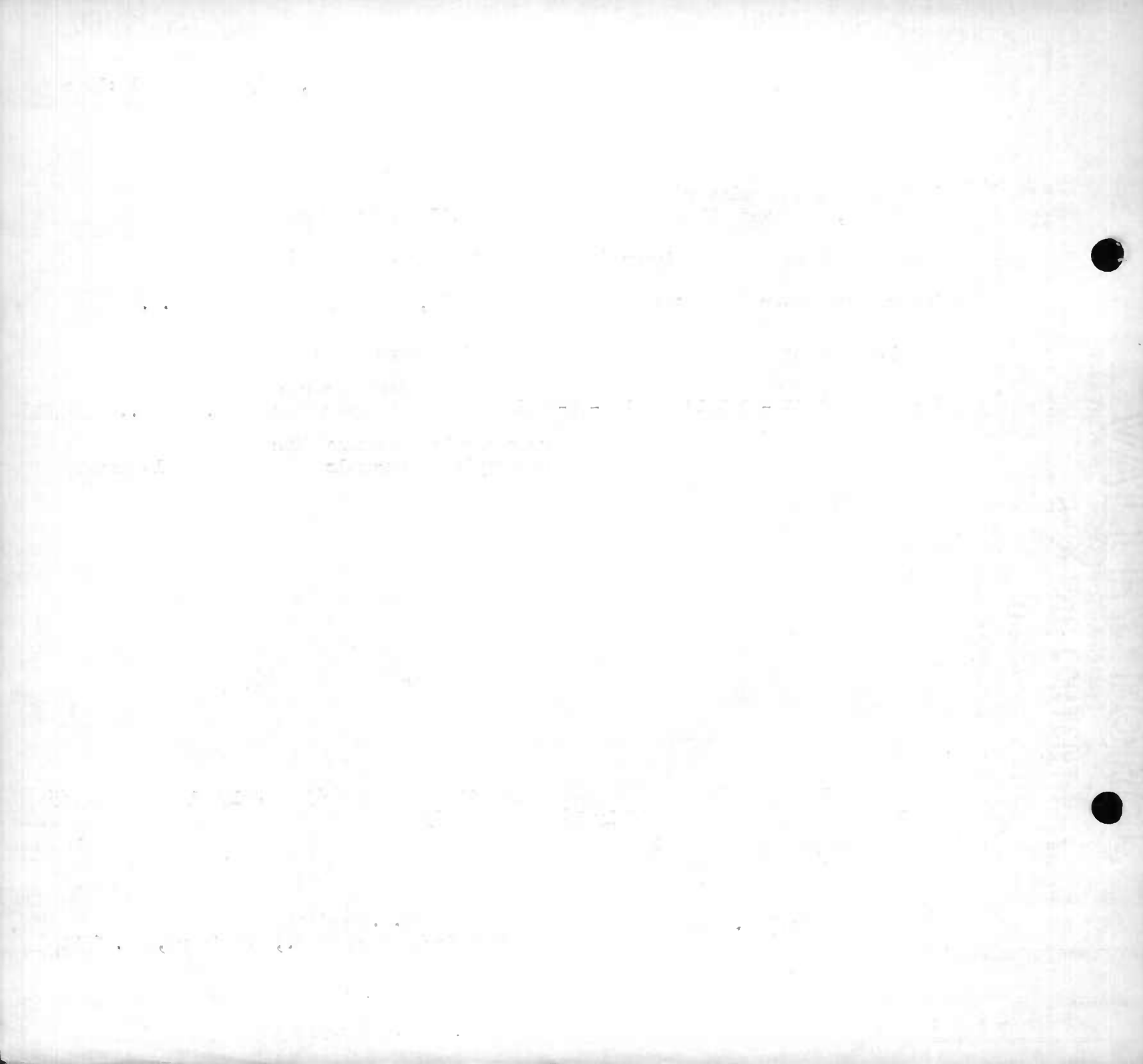


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|--|---|--|
| BIRTH NO. 65 7460 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7460 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) STREAMS, JAMES MATTHEWS | | | 2. DATE AND HOUR OF DEATH
July 16, 1965 12:35 p M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

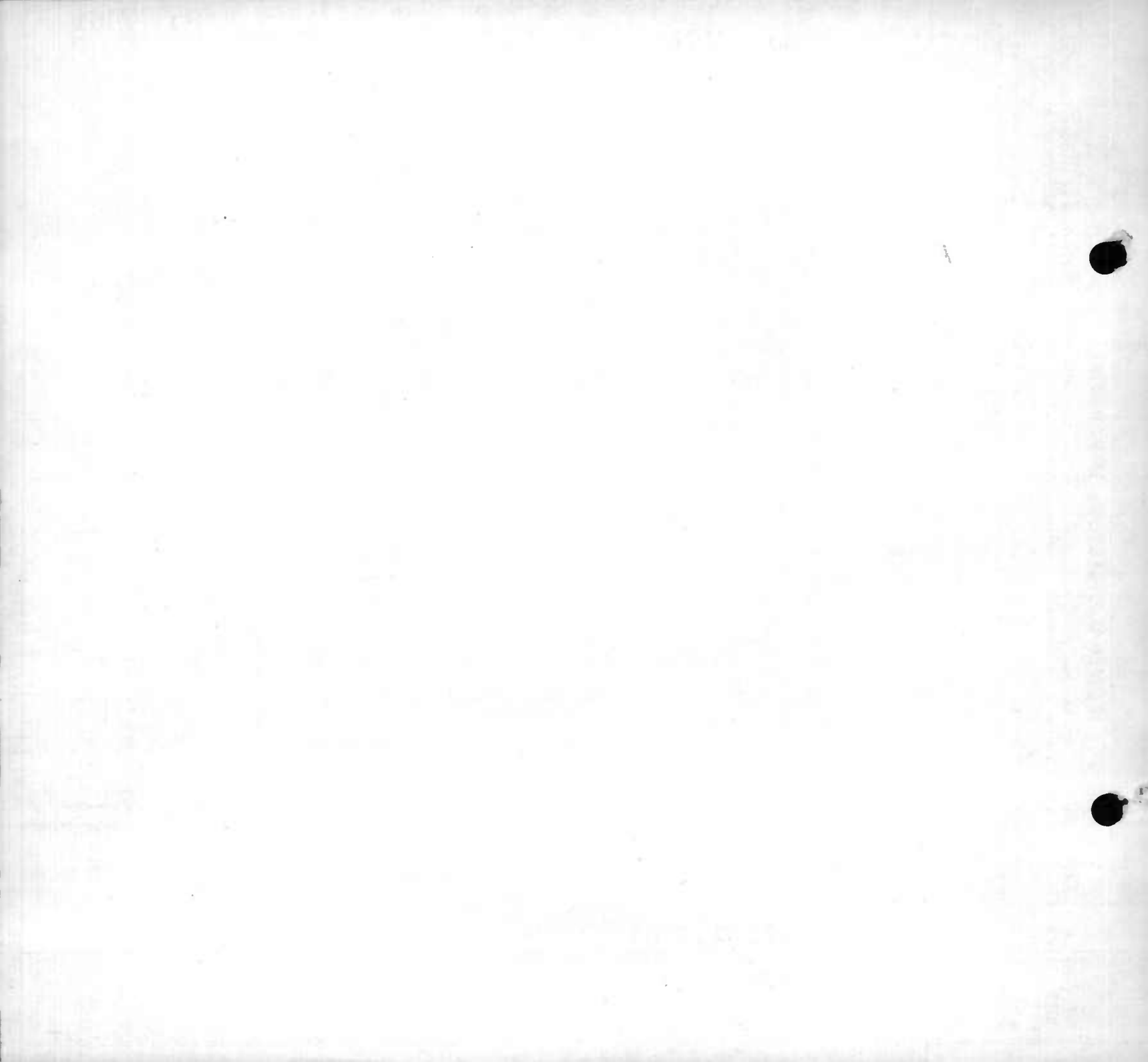
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 14-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
1733 Linden Avenue | | |
| 5. SEX
Male | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Divorced | 8. DATE OF BIRTH
3/17/1900 | 9. AGE (In years last birthday)
65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laboratory Worker | | 10B. KIND OF BUSINESS OR INDUSTRY
Womens Hospital | 11. BIRTHPLACE (State or foreign country)
Bowie, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A |
| 13. FATHER'S NAME
William Streams | | | 14. MOTHER'S MAIDEN NAME
Mina Heven | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 7/2/17 - 3/3/19 | | 16. SOCIAL SECURITY NO.
218-09-0561 | 17. INFORMANT ADDRESS
VA Hospital Records
3900 Loch Raven Boulevard, Balto., Md 21218 | | |
| 18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Bronchogenic Carcinoma With Metastasis to Adrenals
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH
Bronchogenic Carcinoma With Metastasis to Adrenals
(A) DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
10 months |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from May 21 19 65 to July 16 19 65 , that (X) (we) last saw the deceased alive on July 16 19 65 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE
Paul M. Leand | | | 23B. DATE SIGNED
7/16/65 | | |
| 23C. PHYSICIAN'S NAME (Type)
Paul M. Leand | | | 23D. ADDRESS
V.A. Hospital
3900 Loch Raven Blvd., Baltimore, Md. 21218 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | 24B. DATE
7-21-65 | 24C. NAME of CEMETERY or CREMATORY
Bethesda N.Y. Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
George H. Vela 1348 N. Calhoun St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 7461 | | CERTIFICATE OF DEATH | | Registered No. 65 7461 | |
|--|------------------|---|----------------------------|--|----------------------------|--|-----------------------------|------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) Mary Heigh (unit # 332-645) | | 2. DATE AND HOUR OF DEATH
7/17/65 4:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | 5303 Chrysler Ave. #7 Baltimore Maryland | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
SINAI HOSPITAL OF Baltimore Baltimore, Maryland 21215 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | D. STREET ADDRESS (If rural, give location)
5303 Chrysler Ave 28-41 | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
2/7/70 | 9. AGE (In years last birthday)
95 years | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10B. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Calvert County, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Clem Heigh | | | | 14. MOTHER'S MAIDEN NAME
Ross | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Ada Hamilton 27-07 | | ADDRESS
gwynns Falls Baltimore | | | |
| 18. 430.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO
Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH
38 hours | | | |
| | | | | (B) DUE TO
Atherosclerotic Coronary Artery Disease | | NOT KNOWN | | | |
| | | | | (C) _____ | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary edema | | | | | | | | | |
| 19A. DATE OF OPERATION
None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NONE | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 7/16/65 8:55AM 19 65 to 7/17/65 19 65, that (H) (we) last saw the deceased alive on 7/17/65 19 65 and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE
George Banks | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/17/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
George Banks | | | | 23D. ADDRESS
Sinai Hospital of Baltimore Baltimore, Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-21-65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt Auburn Cem. | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fairley | | 25C. FUNERAL DIRECTOR
George A. Felt | | ADDRESS
1348 N. Calhoun St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

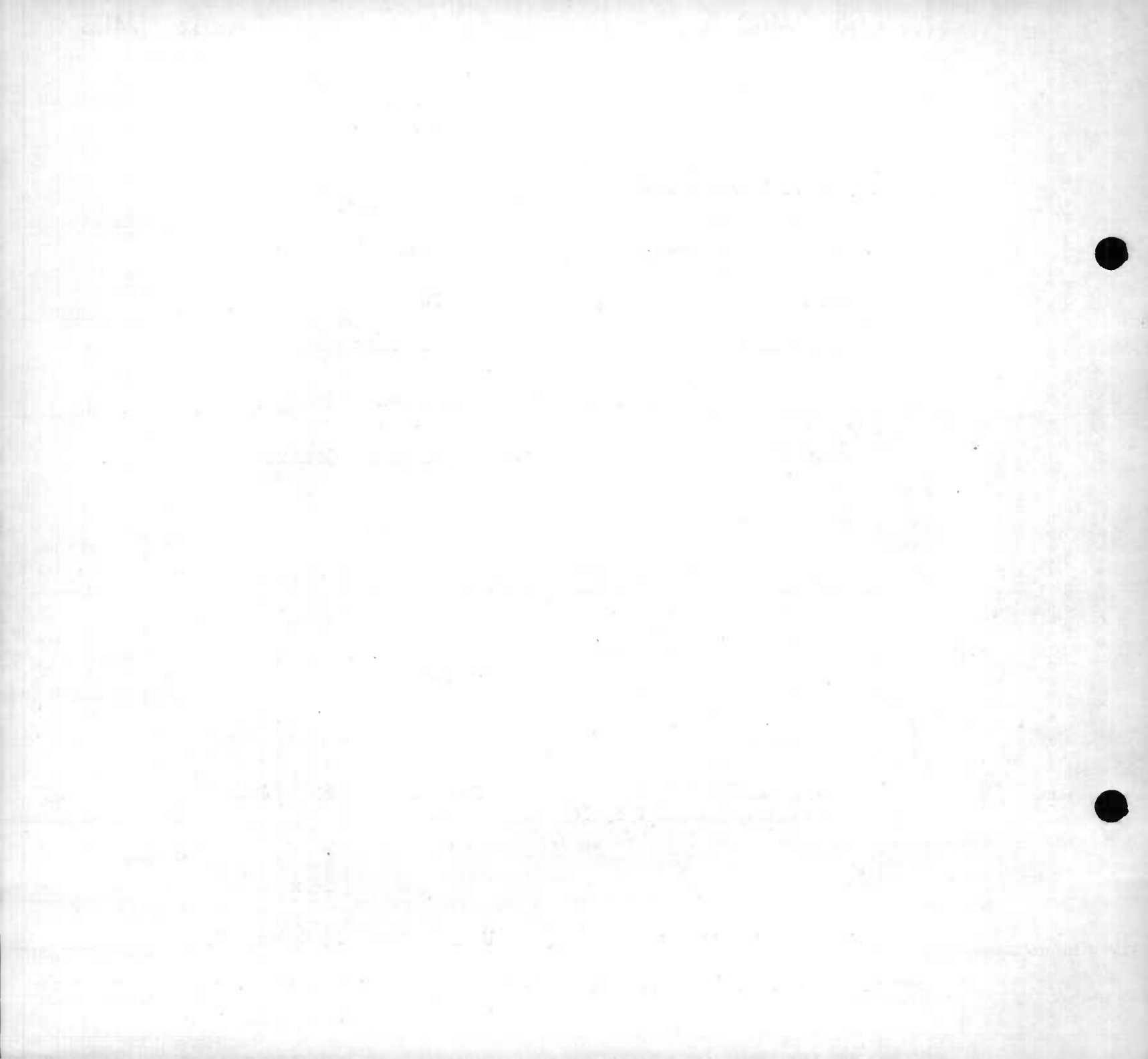
| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 65 7462 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7462 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Clara Pratt | | | July 15, 1965 2:08 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
1514 Division Street
Baltimore, Maryland | | | A. STATE Maryland
B. COUNTY 14-03 | | |
| 5. SEX Female | | | 6. RACE Negro | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Widowed | | | 8. DATE OF BIRTH 9-10-1898 | | |
| 9. AGE (In years last birthday) 66 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME George Bradford | | | 14. MOTHER'S MAIDEN NAME Harriette | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT Joseph Pratt | | | ADDRESS 1822 Walbrook Ave. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cerebrovascular Ac.
Arteriosclerosis | | | | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 30, 1965 to July 15, 1965, that (I) (we) lost saw the deceased alive on July 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alvin Thompson | | | 23B. DATE SIGNED July 16, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) Alvin Thompson | | | 23D. ADDRESS 1514 Division Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/20/65 | | 24C. NAME of CEMETERY or CREMATORY Balto. Natl. Cem. | |
| 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | 24F. NAME OF REGISTRAR Robert E. Fairley | |
| 24G. FUNERAL DIRECTOR George A. Kilar | | 24H. ADDRESS 1348 N. Calhoun St | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|---|--|--|--|
| BIRTH NO. M200 65 7463 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 7463 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) ELIZABETH CORDELIA MEEKS | | | 2. DATE AND HOUR OF DEATH
July 16, 1965 6 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Public Health Service Hospital
Wyman Pk. Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE NJ
B. COUNTY K-27
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Eatontown
D. STREET ADDRESS (If rural, give location)
79 Reynolds Drive | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Single | 8. DATE OF BIRTH
2/15/47 | 9. AGE (In years last birthday)
18 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | | 11. BIRTHPLACE (State or foreign country)
NJ | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Clarence Meeks | | | 14. MOTHER'S MAIDEN NAME
Frances Wolcott | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
157-40-5984 | | 17. INFORMANT
Records- US PHS Hospital, Balto, Md. |
| 18. 204.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Acute myelogenous leukemia
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Acute myelogenous leukemia
DUE TO
(B) 3 mos.
DUE TO
(C) | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from June 21 1965 to July 16 1965 that (X) (we) last saw the deceased alive on July 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
James E. Taylor, Jr.
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
7/ 16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
James E. Taylor, Jr., Sr. Surgeon (R).D. | | | | 23D. ADDRESS
US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
July 16/65 | | 24C. NAME of CEMETERY or CREMATORY
Glenwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State)
West Long Branch, New Jersey | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR
R. E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS
Wm. J. Pickens & Sons 74 Pk. Flies. 17th St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7464 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 7464 | | |
|--|-----------------------------|--|---|-------------------------------------|---|--|--|--|---------|--|
| 1. NAME OF DECEASED
(Type or Print) Jenkins, Benjamin F. | | | | | | 2. DATE AND HOUR OF DEATH
7/15/65 3:40 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland B. COUNTY 15-12 | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Veterans Administration Hospital
3900 Loch Raven Blvd.
Baltimore, Maryland 21218 | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | | |
| D. STREET ADDRESS (If rural, give location)
3508 Greenspring Ave. 21211 | | | | | | | | | | |
| 5. SEX
Male | 6. RACE
Caucasian | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married | | 8. DATE OF BIRTH
11/19/88 | 9. AGE (In years last birthday)
76 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lineman Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY
Gas Co. & Elec. Co. | | 11. BIRTHPLACE (State or foreign country)
Missouri | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Richard, Jenkins | | | | | 14. MOTHER'S MAIDEN NAME
Alamba Worley | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Yes 10/24/13 to 11/6/19 | | | 16. SOCIAL SECURITY NO.
212 05 5842 | | 17. INFORMANT
Veterans Hospital Records
Baltimore, Maryland 21218 | | | | ADDRESS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia
(A) DUE TO
Metastatic Carcinoma of Liver
(B) DUE TO
Bronchiolar Carcinoma
(C) _____
INTERVAL BETWEEN ONSET AND DEATH
3 days
1 yr.
4 yrs. | | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from July 6, 19 65 to July 15, 19 65 , that (X) (we) lost saw the deceased alive on July 15, 19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE

M.D. Robert W. Hamilton | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 15, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type)
Robert W. Hamilton | | | | | | 23D. ADDRESS
M.D. Veterans Hospital, Balto., Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 24B. DATE
7/20/65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore National | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | 25B. NAME OF REGISTRAR
Robert E. Farker, M.D. | | 25C. FUNERAL DIRECTOR
William J. Ticken & Son Inc | | ADDRESS
17 W. Calne | | | |

65 7465

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 7465

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM F. CHAMBERS

2. DATE AND HOUR PRONOUNCED DEAD

July 16, 1965 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 20-08

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

202 S. Loudon Avenue

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 18, 1924

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Golden Key Home Corp.

11. BIRTHPLACE (State or foreign country)

Colorado

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

513-30-0401

17. INFORMANT

ADDRESS

Mrs. Doris C. Chambers 202 S. Loudon Ave. 29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

July 20, 1965

23C. NAME of CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Pickner & Sons 119 Pa. Ave - 17-148

ADDRESS

WALTER D. ROSE

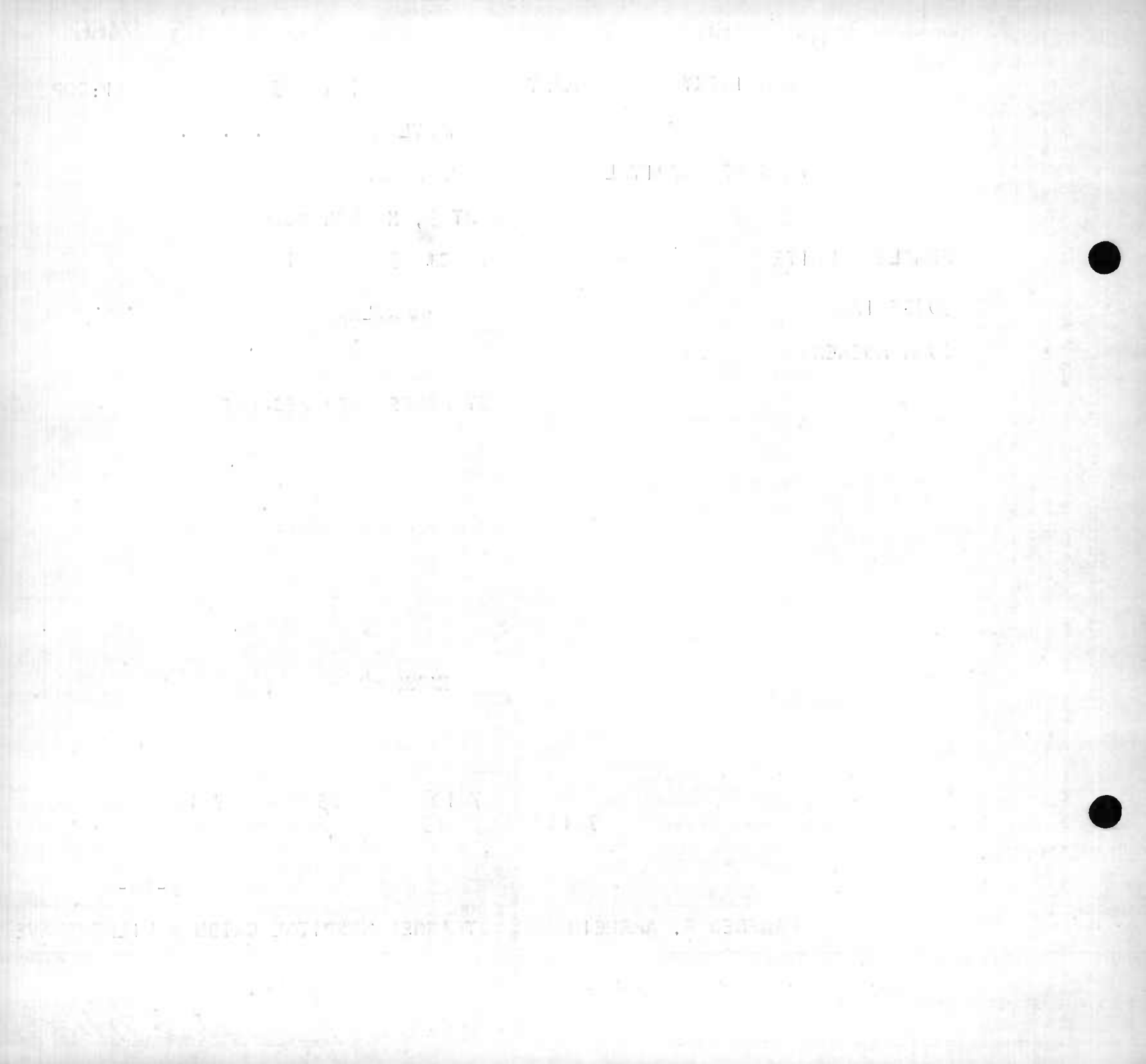
[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|--|--|
| BIRTH NO. 65 7466 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 7466 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | DEMBINSKY MARY B | | 2. DATE AND HOUR OF DEATH
7 16 65 1:00P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY
MARYLAND A. A. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
PASADENA 52-00
D. STREET ADDRESS (If rural, give location)
RT 3, BOX 268 | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED, X Married | | 8. DATE OF BIRTH
10 13 83 | 9. AGE (In years last birthday)
81 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
JOHN ROEMER | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT ADDRESS
ST AGNES HOSP RECORDS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.)
420.1 I
MASSIVE MYOCARDIAL INFARCTION
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST. | | CAUSE OF DEATH
(A) MASSIVE MYOCARDIAL INFARCTION
(B) ATHEROSCLEROTIC HEART DIS.
(C) | | INTERVAL BETWEEN ONSET AND DEATH
7 days - | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
X YES NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 10 65 to 7 16 1965 , that (I) (we) last saw the deceased alive on 7 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Manfred F. Amrhein</i>
M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED
7-16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
MANFRED F. AMRHEIN | | | | 23D. ADDRESS
ST AGNES HOSPITAL CATON & WILKENS AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/19/65 | | 24C. NAME of CEMETERY or CREMATORY
Western | |
| 24D. LOCATION
Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR
<i>William J. Tuckman</i> | | 25D. ADDRESS
<i>W. H. R. Co.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|--|---|
| BIRTH NO. 65 7467 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7467 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) LAURA STAFFORD WIGHT | | 2. DATE AND HOUR OF DEATH
7/16/65 7:45 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE MARYLAND B. COUNTY Balt | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 33-00 | | | |
| | | D. STREET ADDRESS (If rural, give location)
423 HAWTHORNE ROAD | | | |
| 5. SEX
FEMALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
9/4/1882 | 9. AGE (In years lost birthday)
82 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Conn. | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
William H. Stafford | | | 14. MOTHER'S MAIDEN NAME
Hattie L. Horton | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Mrs Lynda Buckler | | ADDRESS
423 Hawthorne Rd
Balt, Md |
| 18. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Renal Insufficiency
DUE TO
(B) DUE TO
(C) Arteriosclerotic Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary Emphysema | | | | | |
| 19A. DATE OF OPERATION
O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/7 to 7/16 1965, that (I) (we) last saw the deceased alive on 7/16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Donald G. Hall | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
DONALD G. HALL | | 23D. ADDRESS
M.D. UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
7/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
Oakgrove | |
| 24D. LOCATION (City, town, or county) (State)
Springfield, Mass. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Wm J. Lickona Mrs. N. B. Lickona | |

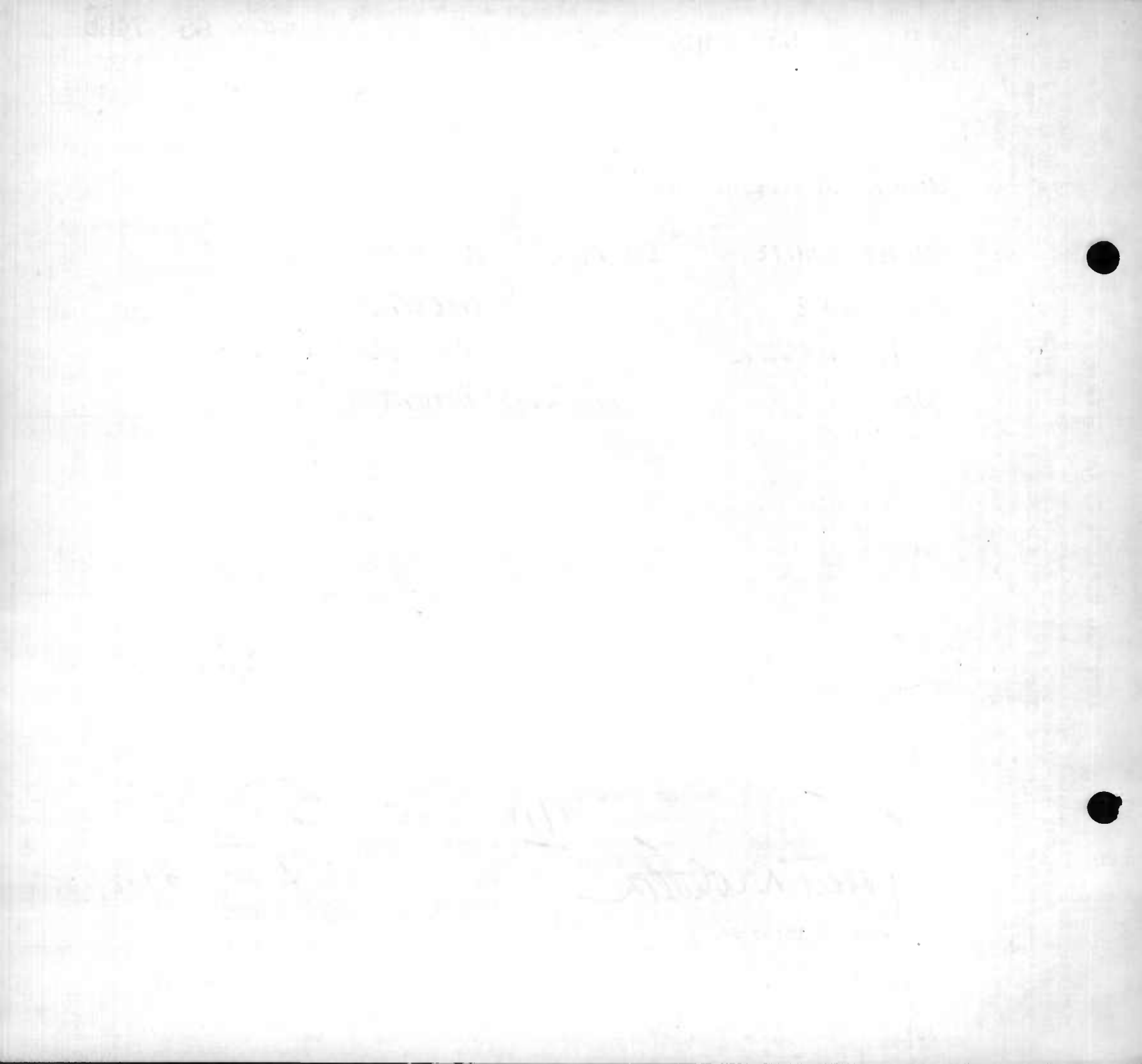
WILLIAM H. HARRIS

WILLIAM H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 7468 | |
|--|--|--|--|---|--|--|--|---|--|--|--|
| BIRTH NO.
65 7468 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) THOMPSON - GERTIE L | | | | | | 2. DATE AND HOUR OF DEATH
7/18/65 7:00A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY CECIL | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSPITAL | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
COLORA 5700 | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | | |
| 5. SEX
FEMALE | | 6. RACE
WHITE | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | | 8. DATE OF BIRTH
10-13-29 | | 9. AGE (In years lost birthday)
35 | | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
GEORGIA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
J.T. CHESSER | | | | | | 14. MOTHER'S MAIDEN NAME
IVA LEE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | | | 16. SOCIAL SECURITY NO.
UNKNOWN | | 17. INFORMANT
PATIENT | | | | ADDRESS | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | (A) UREMIA
DUE TO
(B) BILATERAL ATROPHY OF KIDNEYS
DUE TO
(C) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 6/26 19 65 to 7/18 19 65, that (we) last saw the deceased alive on 7/18 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Robert N. Whitehouse | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/18/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. Robert Whitehouse | | | | | | 23D. ADDRESS
M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Removal | | 24B. DATE
7/19/65 | | 24C. NAME OF CEMETERY or CREMATORY
Sardis | | | | 24D. LOCATION (City, town, or county) (State)
Folkston Georgia | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | | 25B. NAME OF REGISTRAR
R. E. Fawcett, M.D. | | | | 25C. FUNERAL DIRECTOR
William J. Dickner + Sons North + Pa. Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 65 7469 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7469 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Julia Mass Smith | | | 2. DATE AND HOUR OF DEATH
July 17, 1965 6 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
704 E. 41st St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission)
A. STATE Md.
B. COUNTY 9-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
704 E. 41st St. | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | 8. DATE OF BIRTH
Sept. 11, 1873 | 9. AGE (In years last birthday)
91 | If Under 1 Yr. Months: Days: Hours: Min.
If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Baltimore | |
| 13. FATHER'S NAME
Charles Philip Maas | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS
Mrs. J.B. Mettam 704 E 41st St. Balto. 12 |
| 18. 3-2X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Cerebral thrombosis
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Cerebral
Cerebral thrombosis
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
prior cerebral thrombosis | | | CAUSE OF DEATH
(A) Cerebral thrombosis
DUE TO
(B) Cerebral
DUE TO Cerebral thrombosis
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
about 2 mos |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/17/1965 to 7/17/1965 , that (I) (we) last saw the deceased alive on 7/15/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
William F. Renner M.D. | | | 23B. DATE SIGNED
7/19/65 | | |
| 23C. PHYSICIAN'S NAME (Type)
William F. Renner M.D. | | | 23D. ADDRESS
11 W. 29th St. Baltimore | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
July 19, 1965 | | 24C. NAME of CEMETERY or CREMATORY
Loudon Park | |
| 24D. LOCATION
Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 24F. NAME OF REGISTRAR
Robert E. Fadden | |
| 24G. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 24H. NAME OF REGISTRAR
Robert E. Fadden | | 24I. FUNERAL DIRECTOR ADDRESS
Wm. T. Tucker & Sons, 17-Md. | |

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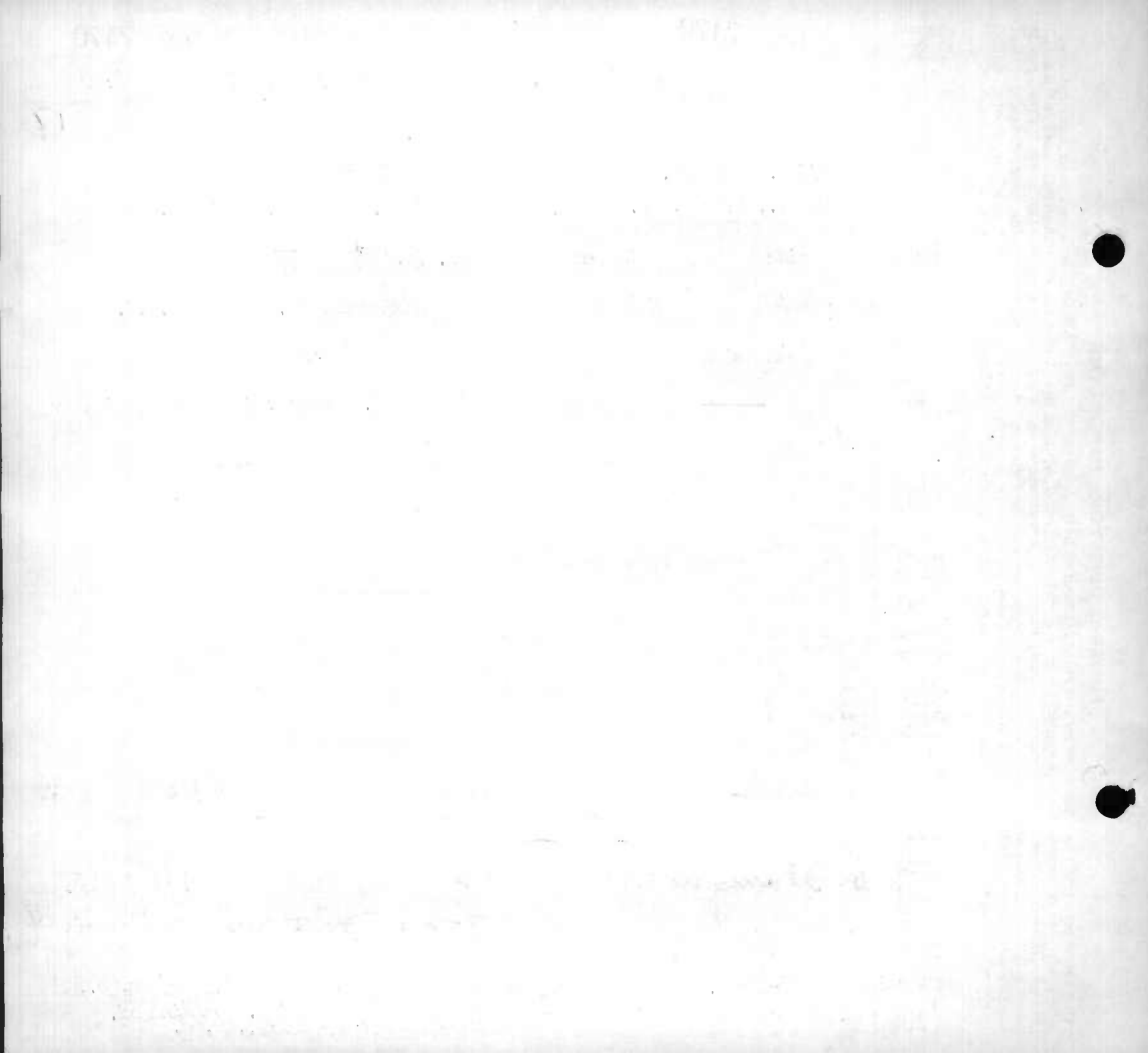
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William T. Jones

1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 7470 | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| BIRTH NO. 65 7470 | | | | | | | | | | M. | |
| M.E. CASE NO. | | | | | | | | | | M. | |
| 1. NAME OF DECEASED (Type or Print) | | | | | | | | | | 2. DATE AND HOUR OF DEATH | |
| Anna Brodka . | | | | | | | | | | July 16, 1965 8:00 P | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | | | | | A. STATE B. COUNTY | |
| 617 S. East Ave. Balto., 21224, Md. | | | | | | | | | | Md. 26-11 | |
| 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | | | | | | | 8. DATE OF BIRTH 9. AGE (In years last birthday) | |
| Female White Widowed | | | | | | | | | | Sept. 19, 1887 77 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | | | | | 11. BIRTHPLACE (State or foreign country) | |
| House Work | | | | | | | | | | Baltimore, Md. | |
| 13. FATHER'S NAME | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Smith | | | | | | | | | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | | | | | 16. SOCIAL SECURITY NO. | |
| No | | | | | | | | | | None | |
| 17. INFORMANT | | | | | | | | | | ADDRESS | |
| Elizabeth C. Freyer | | | | | | | | | | 515 Chestnut Hill Av | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Coronary Thrombosis. | | | | | | | | | | | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | | | | | | | | |
| Arterio sclerotic heart disease. | | | | | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 21A. DATE OF OPERATION 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21C. AUTOPSY? (Yes or No) 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | |
| 23D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 23E. INJURY OCCURRED While At Work Not While At Work 23F. HOW DID INJURY OCCUR? | | | | | | | | | | | |
| 24. I certify that (I) (the hospital) attended the deceased from 10/23 1950 to 7/16 1965 that (I) (we) last saw the deceased alive on June 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 25A. SIGNATURE 25B. DATE SIGNED | | | | | | | | | | | |
| E. A. Flanagan Jr. M.D. 7/17/65 | | | | | | | | | | | |
| 26C. PHYSICIAN'S NAME (Type) 26D. ADDRESS | | | | | | | | | | | |
| 3501 Fair Ave. Baltimore, Md. | | | | | | | | | | | |
| 27A. BURIAL CREMATION, REMOVAL (Specify) 27B. DATE 27C. NAME OF CEMETERY or CREMATORY 27D. LOCATION (City, town, or county) (State) | | | | | | | | | | | |
| Burial 7-20-65 Sacred Heart Cemetery 7401 German Hill Rd. Ba. Co., Md. | | | | | | | | | | | |
| 28A. DATE REC'D BY HEALTH DEPT. 28B. NAME OF REGISTRAR 28C. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | |
| JUL 19 1965 Robert E. Farley, M.D. Charles J. Zeiber 901 S. Conkling St. Balto., Md. | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|---|--|---|
| BIRTH NO. 65 7471 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7471 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) EDWARD T. BACON, Sr. | | | 2. DATE AND HOUR OF DEATH
JULY 14, 1965 5:00 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

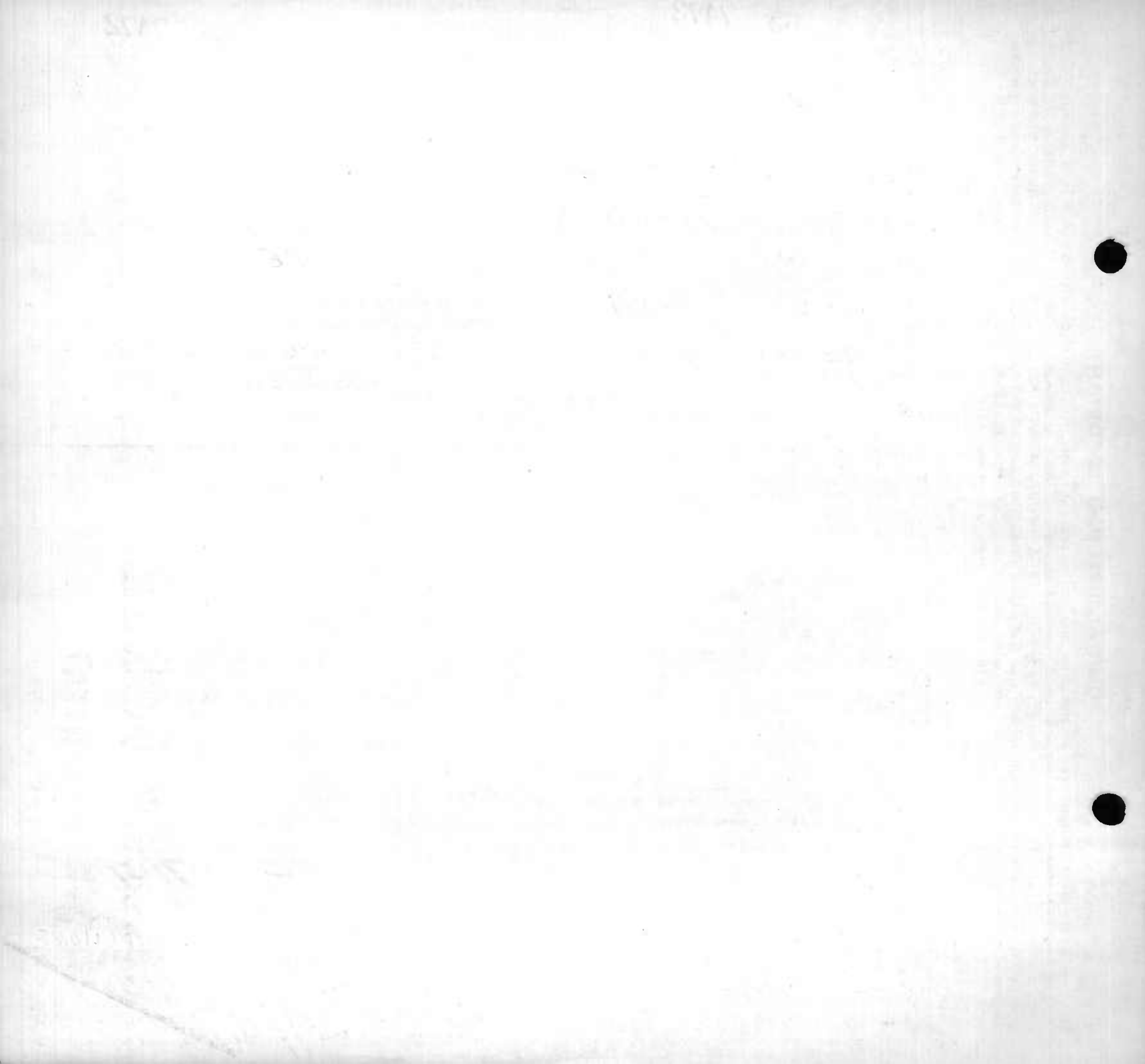
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
FRANKLIN SQUARE HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 17401
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 403 N. PACA ST. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2/8/1893 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gold Gilder | | 10B. KIND OF BUSINESS OR INDUSTRY Self Employed | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME JAMES BACON | | | 14. MOTHER'S MAIDEN NAME LYDIA GALLIGAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I | | 16. SOCIAL SECURITY NO. 29-32-2538 | | 17. INFORMANT ADDRESS Ida M. Bacon 403 N. Paca St. | |
| 18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost.
diabetes mellitus | | | CAUSE OF DEATH
DEAD ON ARRIVAL
(A) DUE TO uremia
(B) DUE TO diabetes mellitus
(C) | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 5, 1965 to DEAD ON 19 , that (I) (we) last saw the deceased alive on ARRIVAL 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Muner | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) Silvino B. Muner | | | 23D. ADDRESS F.S.H. 160 N. Calhoun St. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/19/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | 25B. NAME OF REGISTRAR Robert E. Fahren | | 25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker | |

6/11/1917

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|--------------|---|---|---------------------------------------|--|--|-------------------------------------|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 7472 | | | | | |
| BIRTH NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| M.E. CASE NO. | | | | | 15 JULY 1965 12:05 PM COT M. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) GREEN, JOSEPH AARON | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNIVERSITY HOSPITAL
REDWOOD & GREEN ST.
BALTO MARYLAND | | | | | A. STATE
MD. CARROLL COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
MOUNT AIRY 36-00 | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location)
2 | | | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
3/2/09 | 9. AGE (In years last birthday)
56 | If Under 1 Yr.
Months: Days: | | If Under 24 Hrs.
Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER | | | 10B. KIND OF BUSINESS OR INDUSTRY
FARM | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
DELBERT GREEN | | | | | 14. MOTHER'S MAIDEN NAME
GOLDIE - MARYETTA PARRISH | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO NO | | | 16. SOCIAL SECURITY NO.
213-34-3992 | | 17. INFORMANT
WIFE MRS. HAZEL GREEN
ADDRESS
MOUNT AIRY # 2 | | | | | |
| 18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH
72 HRS | | | | | |
| 19A. DATE OF OPERATION
O | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/12 1965 to 7/15 1965, that (I) (we) last saw the deceased alive on 7/15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE
Ronald L. Paul | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/15/65 | | | |
| 23C. PHYSICIAN'S NAME (Type)
RONALD L. PAUL | | | | | 23D. ADDRESS
M.D. UNIVERSITY HOSP, BALTIMORE | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 24B. DATE
7/18/65 | | 24C. NAME OF CEMETERY or CREMATORY
PROVIDENCE CEMETERY | | | 24D. LOCATION (City, town, or county) (State)
GAMBER, CARROLL, MD | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | 25B. NAME OF REGISTRAR
Robert E. Fisher | | | 25C. FUNERAL DIRECTOR
James G. Saffell | | | | |
| | | | | | | ADDRESS
WESTMINSTER, MARYLAND | | | | |



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED

(Type or Print)

Rosalie Moaney Lake

2. DATE AND HOUR PRONOUNCED DEAD

7/12/65

9:25 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

926 N. Carrollton Ave.

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Aug. 21, 1924

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Married

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Phillip A. Moaney

14. MOTHER'S MAIDEN NAME

Ella Winters

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

219-14-2583

17. INFORMANT

Ella Moaney

ADDRESS

Easton, Maryland

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive pulmonary embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Warner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial 7-16-65

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

Coppersville Cem.

23D. LOCATION

Talbott

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

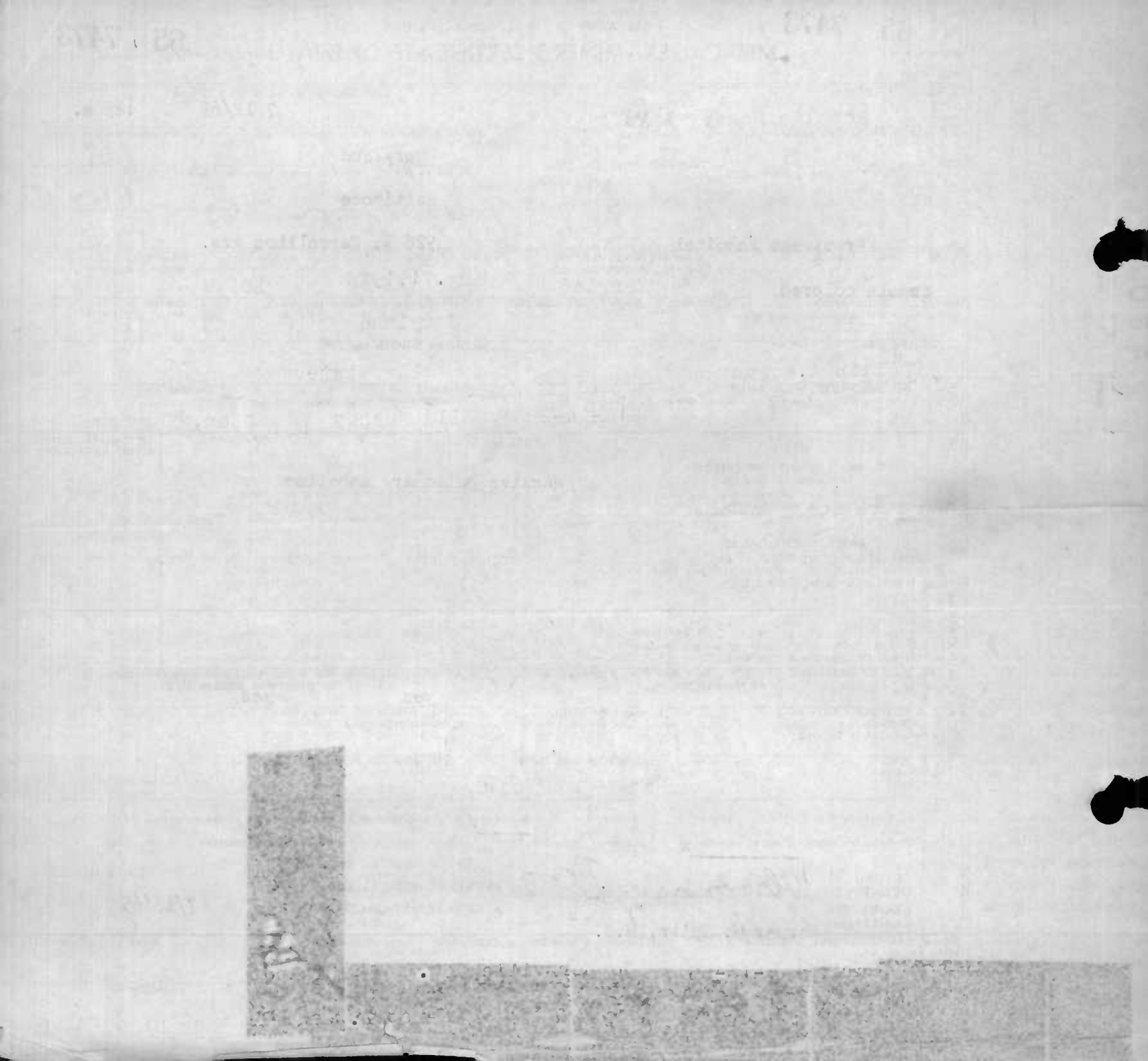
24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

James B. Dashiell Easton, Maryland

ADDRESS



BIRTH NO.

65 7474

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 7474

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH

LADIKA

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 1965

5:40 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

321 Old Riverside Avenue Road

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Dec. 31, 1905

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Time clerk

10B. KIND OF BUSINESS OR INDUSTRY

City of Baltimore

11. BIRTHPLACE (State or foreign country)

Mt. Carmel Pennsylvania U.S.A.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Ladika

14. MOTHER'S MAIDEN NAME

Mary Boltun

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

181-07-7464

17. INFORMANT

Frances Ladika-321 Old Riverside Rd.

ADDRESS

18. 422.1
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7/17/65

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Highway Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

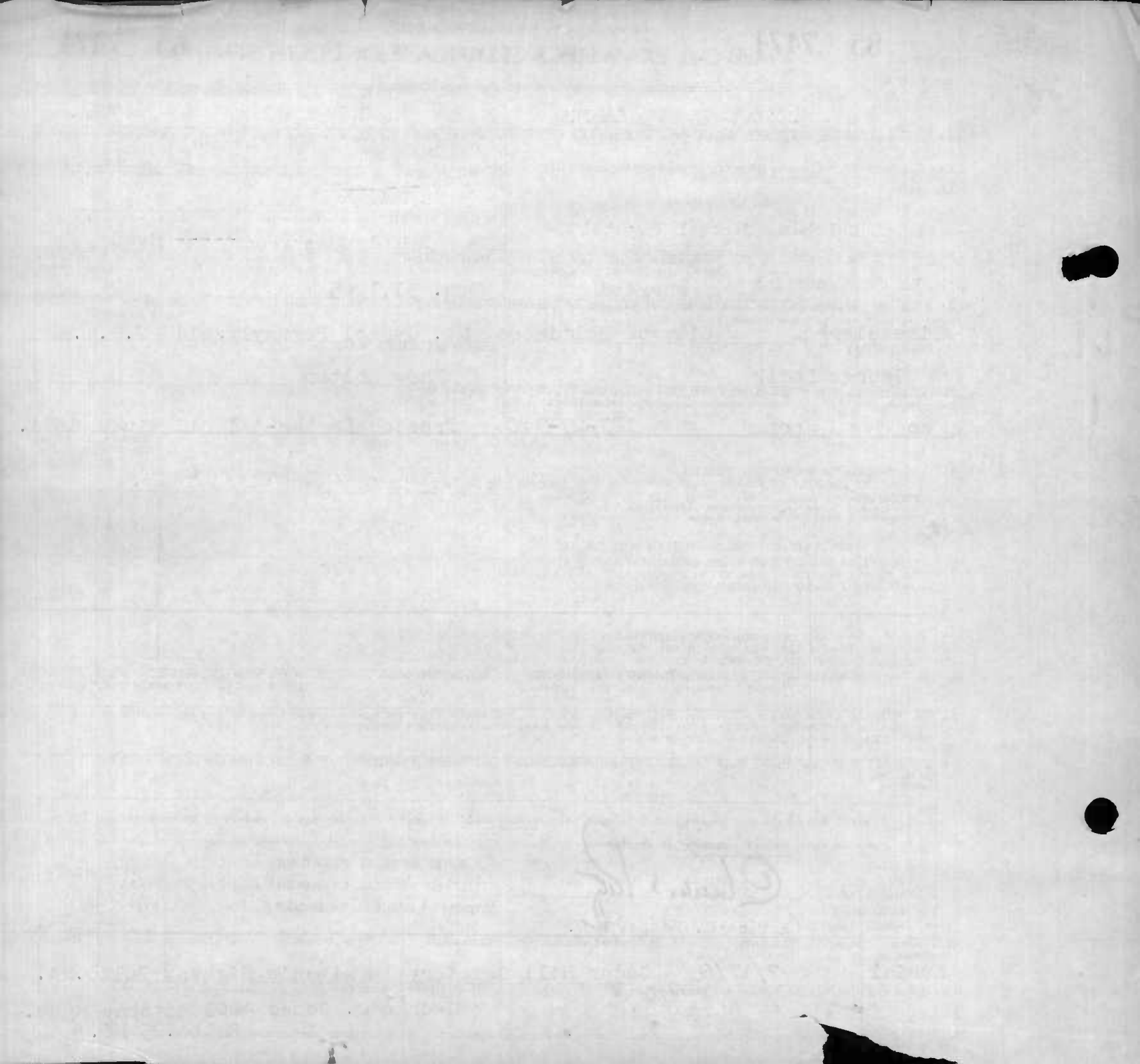
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hghw.
Balto. Md.

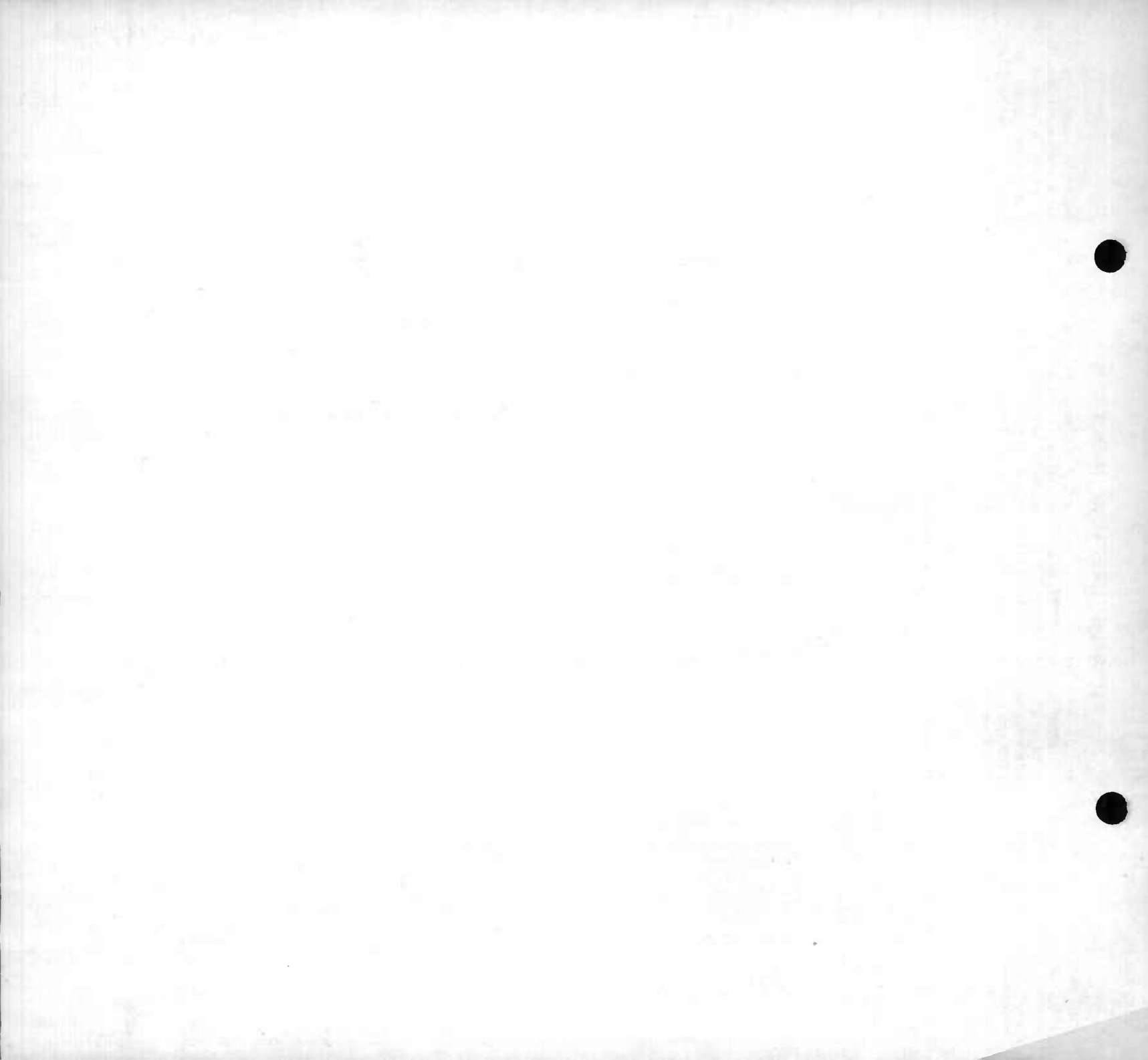
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

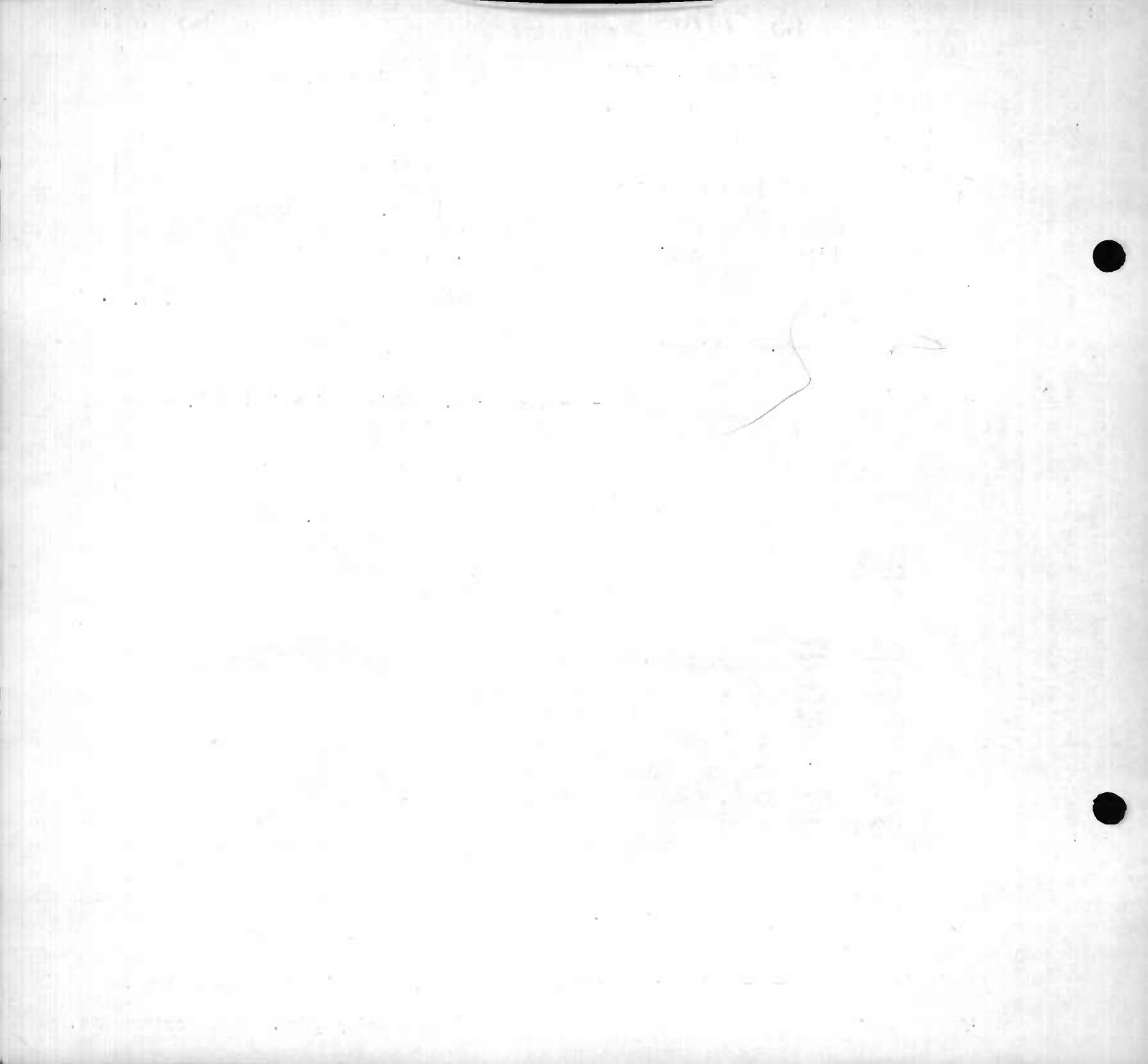
| BIRTH NO. 65 7475 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7475 | |
|---|---------|--|------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | | | Harry Ditman | | 7/16/65 4:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | Maryland | | 18-03 | |
| UNIVERSITY HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 1018 W. Pratt St. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| Male | White | WIDOWED SINGLE | 6/29/1976 | 89 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Unknown | | Unknown | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Ezra Ditman | | | | Mary Jean La Vell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| no | | unknown | | Clarence Ditman 4626 Timonium Rd. Timonium, Md. | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | Carcinoma of Stomach 3 months | | | |
| ANTECEDENT CAUSES | | | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| None | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/29/1965 to 7/16/1965, that (I) (we) last saw the deceased alive on 7/16/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| B. Ann Ward | | | | | | 7/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| B. Ann Ward | | | | 32 S. Greene St. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL, (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 7/19/1965 | | Lorraine Park Cem. | | Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 19 1965 | | Robert E. Taylor | | John J. Cowan & Son, Inc. | | 901 Hollins St. Balt. 23, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7476 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7476 | |
|--|---------|---|------------------|---|------------------------|--|------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | JULIAN BOBINSKI | | July 16, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Church Home & Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 412 S. Wolfe Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months | 11. Under 24 Hrs. Days | 12. Under 24 Hrs. Min. |
| Male | White | Married | Nov. 4, 1891 | 73 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Stevedore | | | | Poland | | U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Andrew Bobinski | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 215-09-3255 | | Mrs. Sophia Bobinski | | 412 S. Wolfe Street | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <i>Acute Coronary Thrombosis</i> | | | |
| ANTECEDENT CAUSES | | | | (B) <i>Generalized Atherosclerosis</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) <i>Hypertension C.V.D.</i> | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED (While At Work) () (Not While At Work) () | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to 7/16/65, that (I) (we) last saw the deceased alive on 7/14/65 and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Taken to Church Home Hosp. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. () Med. Director () Stoll Phys. () | | 23B. DATE SIGNED | |
| <i>M. J. Jaworski</i> | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| M. J. JAWORSKI | | | | 2711 Carter Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 7-20-1965 | | Holy Rosary | | Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 19 1965 | | Robert E. Taylor, M.D. | | Lilly & Zeiler Inc. | | 1901 Eastern Ave. | |



65 7477

BALTIMORE CITY HEALTH DEPARTMENT

65 7477

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILTON

ALLEN

2. DATE AND HOUR PRONOUNCED DEAD

July 15, 1965

12:10 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

217 S. Ann Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

217 S. Ann Street

5. SEX

Male

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

Sept 11, 1904

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance Man

10B. KIND OF BUSINESS OR INDUSTRY

City Hospital

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alexander Allen

14. MOTHER'S MAIDEN NAME

Katherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-07-5450

17. INFORMANT

ADDRESS

Mrs. Constance Boller 2145 Vailthorn Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cor Pulmonale
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Pulmonary Emphysema.
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/15/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-19-1965

23C. NAME of CEMETERY or CREMATORY

HOLY Redeemer

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1965

Robert E. Farley, M.D.

Lilly & Zeiler Inc. 1901 Eastern Ave.

WALL & FORGE

PHOTOGRAPH

Charles R.

FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7478 | | | |
|---|-------------------------|--|------------------------------------|---|--|---|-----------------------|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Eual G. Ashbey | | | | 2. DATE AND HOUR OF DEATH
7-11-65 8:10 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY 2-03 | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
JOHNS HOPKINS HOSPITAL | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE, 31 | | | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
719 S. BOND ST | | | | | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SEP. | 8. DATE OF BIRTH
3-23-24 | 9. AGE (In years last birthday)
41 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Rainelle, W. Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | |
| 13. FATHER'S NAME
EUAL WARD | | | | 14. MOTHER'S MAIDEN NAME
LAURA BELL YOUNG | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
William K. Kisamore | | ADDRESS
719 S. Bond St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
8/1/11
Pulm. hemorrhage, ? pulm edema
alcoholic hepatitis | | | | CAUSE OF DEATH
(A) DUE TO
(B) DUE TO
(C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs.
3 wks | | | |
| 19. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
NO | | 20A. AUTOPSY? (Yes or No)
YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
- | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)
- | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
- | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR?
- | |
| 22. I certify that (H) (this hospital) attended the deceased from 6/2/1965 to 7/11/1965 , that (I) (we) last saw the deceased alive on 7/11/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Robert I. Keimowitz | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/11/65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type)
Robert I. Keimowitz | | M.D. | | 23D. ADDRESS
Johns Hopkins Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-16-1965 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Carmel | | 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR
Lilly & Zeiler Inc. | | ADDRESS
1901 Eastern Ave. | | | | | |

End - 1910

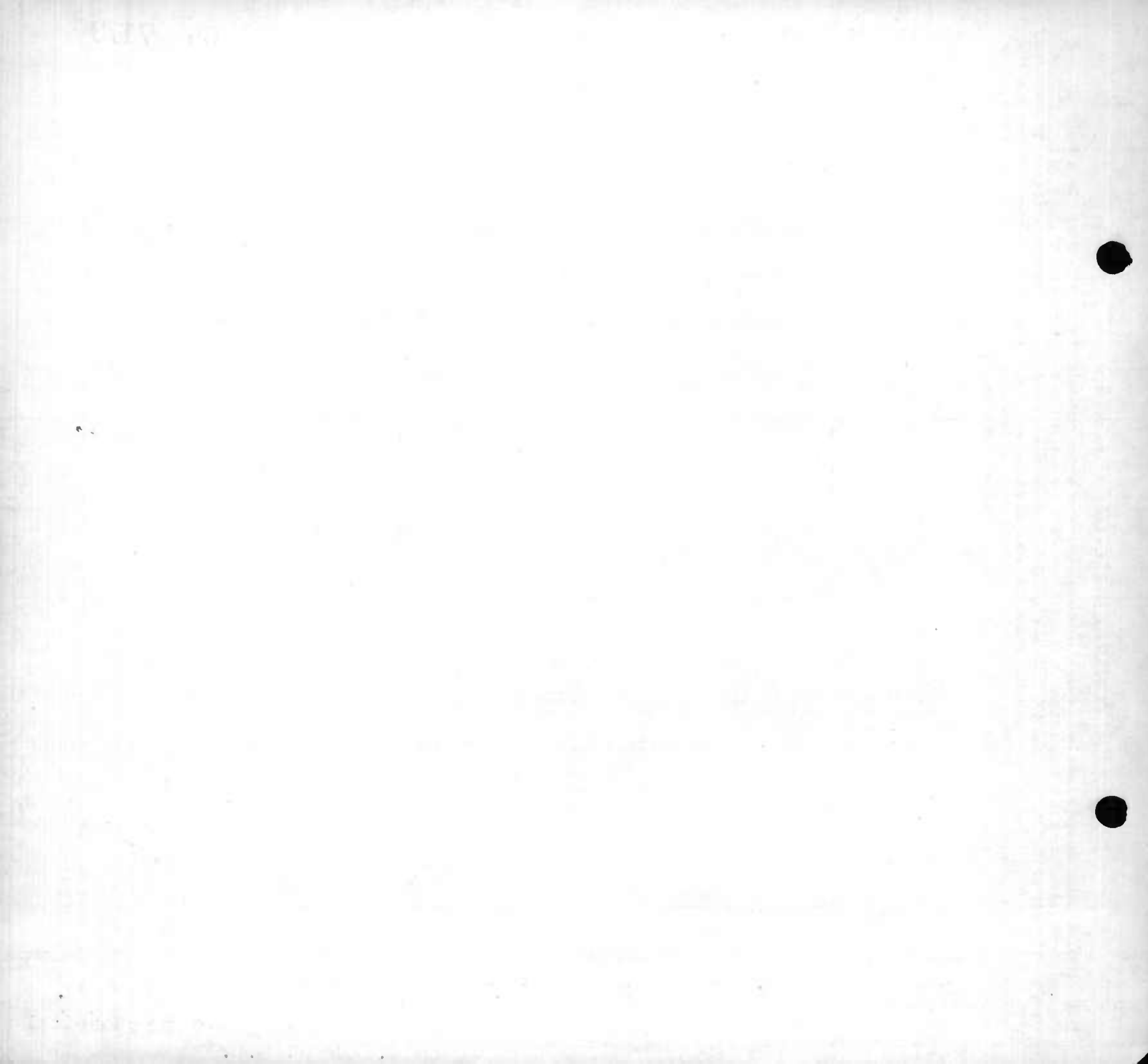
Received of the Treasurer of the
Board of Directors of the
City of New York

for the sum of \$100.00
the sum of \$100.00
the sum of \$100.00
the sum of \$100.00

FUNERAL DIRECTOR: IMPORTANT

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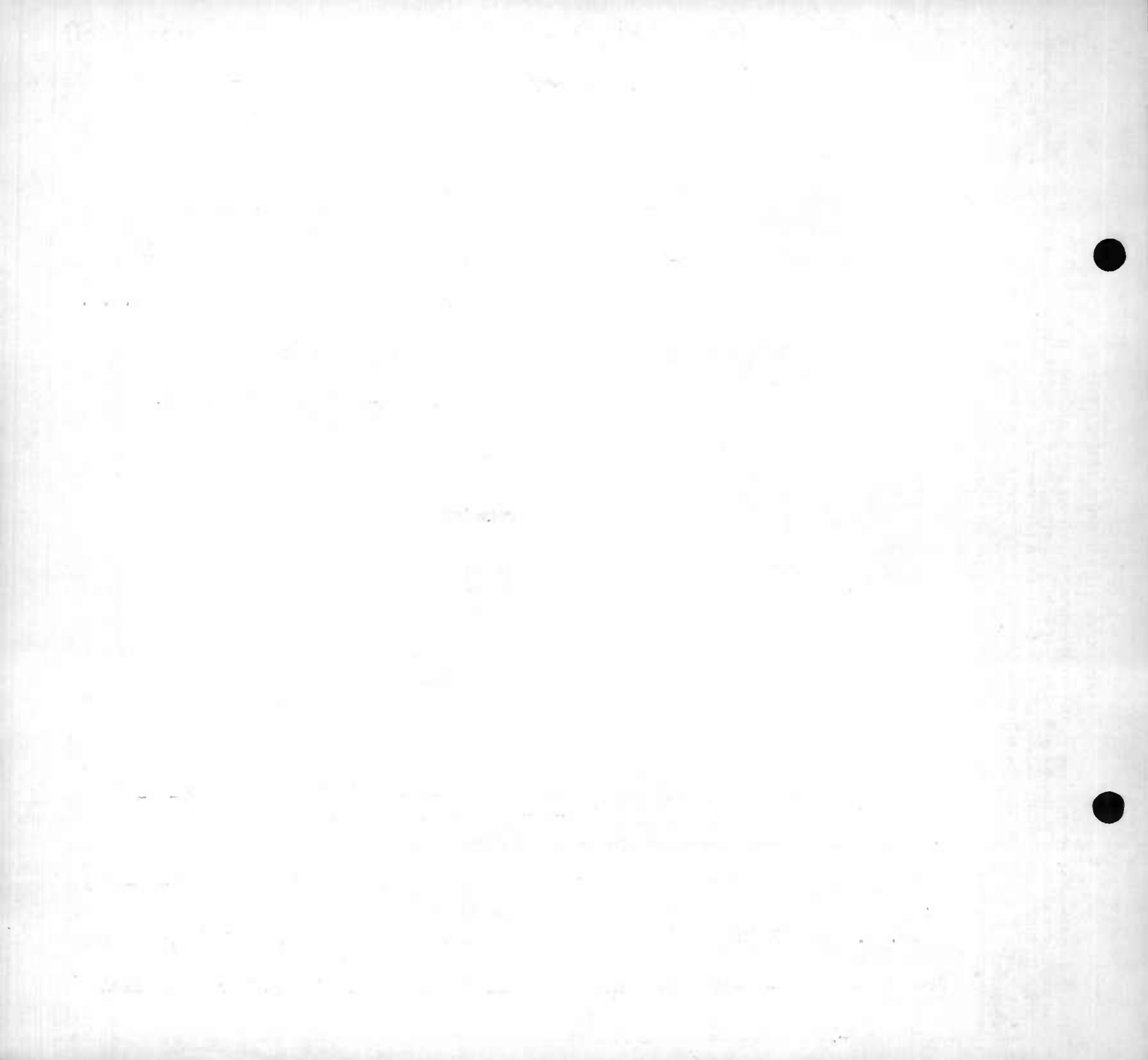
| BIRTH NO. 65-17469 65 7479 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 7479 | |
|--|--|--|--|---|--|---|--|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | BABY (FEMALE) TABOIR | | July 13, 1965 16:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| HOSPITAL for the WOMEN of MARYLAND | | | | BALTO | | 63-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 304 TORNER RD | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| FEMALE | | WHITE | | | | July 13, 1965 | | 4 20 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | | | MARYLAND | | U.S. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Sidney Ernest Tabor | | | | Winifred Celeste Gibson | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | | | Mother | | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) IMMATURITY | | | | 4 hrs from birth | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | | | |
| | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 13 1965 to July 13 1965, that (I) (we) last saw the deceased alive on July 13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Filipina A Silvestre M.D. | | | | July 13, 1965 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Filipina A Silvestre M.D. | | | | 1413 Park Avenue, Baltimore MARYLAND | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Cremation | | 7/16/65 | | Womens Hospital | | Baltimore Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JUL 19 1965 | | Robert E. Taylor | | John E. Adams | | Womens Hospital | | | |
| John E. Adams, M.D. | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

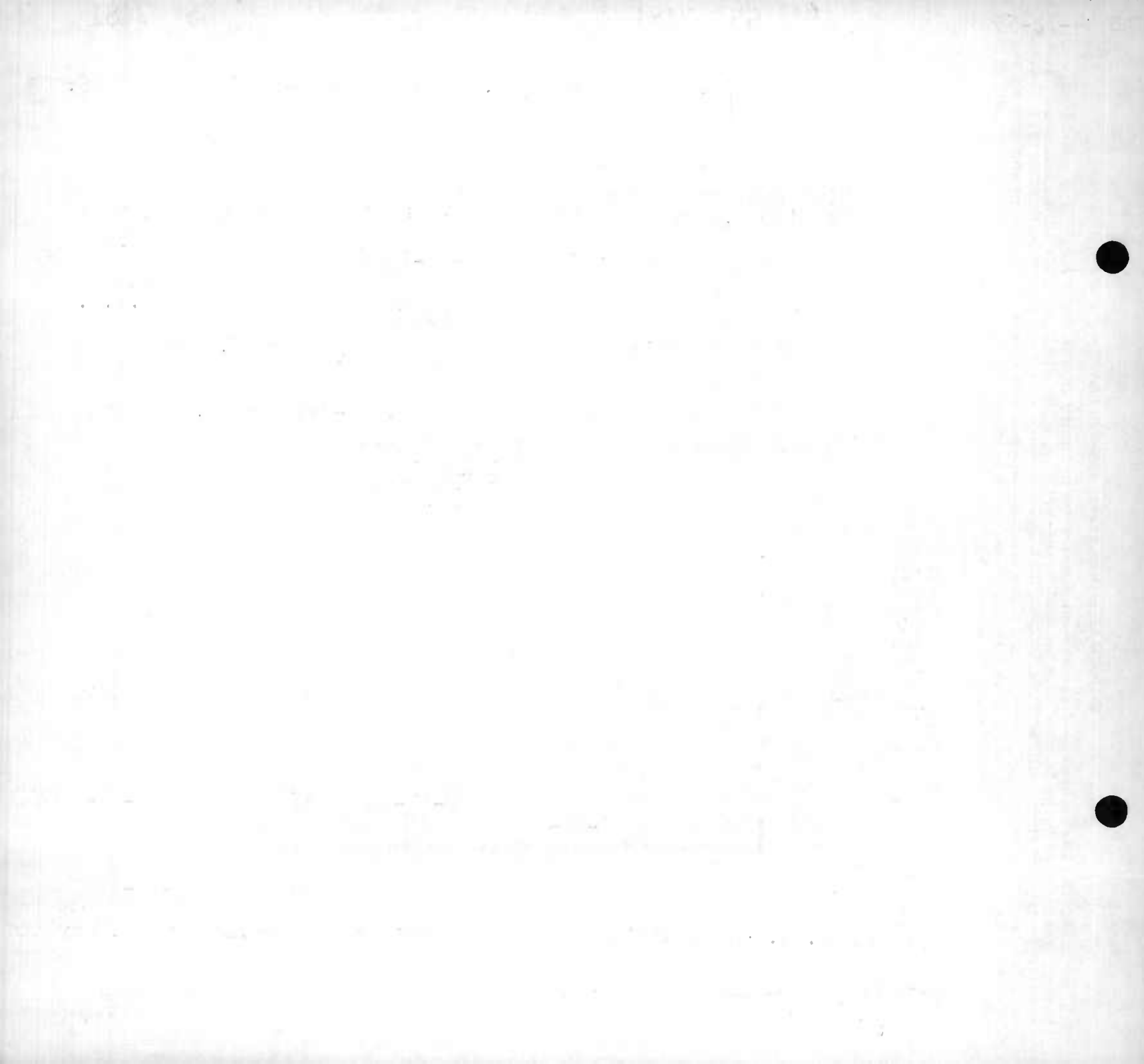
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------|---|------------------|---|-----------------------|--|---------------------------|
| BIRTH NO. <u>65-15037</u> | | 65 7480 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65-7480</u> | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| (Type or Print) | | | | Leggs, Baby Boy "B" - Deceased | | | |
| 2. DATE AND HOUR OF DEATH | | | | 7-13-1965 2:00A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland-21224 | | | | Maryland | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 2323 Linden Avenue, 21217 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 1 Yr. Hours Min. |
| Male | Negro | Never Married | 6-27-1965 | | 16 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| James Leggs | | | | Dorothy Stewart | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | Records: BCH-4940 Eastern Avenue, 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Aspiration | | | |
| ANTECEDENT CAUSES | | | | (B) Prematurity | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-27-19 65 to 7-13-19 65, that (I) (we) last saw the deceased alive on 7-13-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| S. Wayne Klein | | | | 7-13-1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | | | |
| Dr. S. Wayne Klein | | 4940 Eastern Avenue, Baltimore, Maryland | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Cremation | | 7-15-65 | | Baltimore City Hospitals | | Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| JUL 19 1965 | | Robert E. Farkley | | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|---|--|--|
| BIRTH NO. 65-17410-7481 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7481 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED
(Type or Print) Davis, Baby Girl-Mary F. | | | 2. DATE AND HOUR OF DEATH
7-11-1965 6:00P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21218 | | | A. STATE Maryland
B. COUNTY 12-83 | | |
| 5. SEX Female | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | |
| 6. RACE Negro | | | D. STREET ADDRESS (If rural, give location)
2416 North Calvert Street, 21218 | | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married | | | 8. DATE OF BIRTH
7-11-1965 | | 9. AGE (In years last birthday)
20 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Richard Davis | | | 14. MOTHER'S MAIDEN NAME
Mary F. Horton | | |
| 15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Records: BCH-4940 Eastern Avenue 21224 |
| 18. 761.51
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Prolapse of Cord
Fetal Anoxia
Immaturity
Footling Breech | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO | | |
| | | | (B) DUE TO | | |
| | | | (C) DUE TO | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-11-1965 to 7-11-1965 , that (I) (we) last saw the deceased alive on 7-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
S. Wayne Klein | | | | 23B. DATE SIGNED
7-11-1965 | |
| 23C. PHYSICIAN'S NAME (Type)
Dr. S. Wayne Klein | | | | 23D. ADDRESS
4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Cremation | | 24B. DATE
7-12-65 | | 24C. NAME OF CEMETERY or CREMATORY
Baltimore City Hospitals | |
| 24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland 21224 | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 65 7482 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7482 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) <i>Margaretha B. Harris</i> | | 2. DATE AND HOUR OF DEATH
<i>July 10, 1965</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. SEX <i>F</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION
<i>4410 - Parkmont Ave
Baltimore 21206, Md</i> | | A. STATE <i>Maryland</i>
B. COUNTY <i>26-01</i>
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
<i>Baltimore 21206</i>
D. STREET ADDRESS (If rural, give location)
<i>4410 - Parkmont Ave</i> | | 6. RACE <i>W.</i> | |
| 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
<i>Widowed</i> | | 8. DATE OF BIRTH
<i>Feb. 20, 1881</i> | | 9. AGE (In years lost birthday)
<i>84 years</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | | 11. BIRTHPLACE (State or foreign country)
<i>Baltimore - Md</i> | |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 13. FATHER'S NAME
<i>John Bruening</i> | | 14. MOTHER'S MAIDEN NAME
<i>Margaret Wick</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Mrs Gladys E. Foley</i>
<i>4410 - Parkmont Ave - Baltimore</i> | |
| 18. <i>443X I</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) <i>Cerebral Hemorrhage</i>
DUE TO
<i>Heart Disease</i>
(B) <i>Hypertensive - Cardiovascular</i>
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<i>20 days</i>
<i>20 years</i> | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
<i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April 4</i> 19 <i>56</i> to <i>July 10</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>July 9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
<i>Adam G. Swiss</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
<i>July 10, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type)
<i>ADAM G. SWISS</i> | | 23D. ADDRESS
<i>632 Belair Rd. Balti - G. Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 24B. DATE
<i>7/14/1965</i> | | 24C. NAME OF CEMETERY OR CREMATORY
<i>Baltimore Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State)
<i>Baltimore 21205, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT.
<i>JUL 19 1965</i> | | 25B. NAME OF REGISTRAR
<i>Robert E. Farley</i> | |
| 25C. FUNERAL DIRECTOR
<i>Paul B. Wabertons Funeral Home, Inc</i>
<i>6306 - Belair Rd - Baltimore 21246 Md.</i> | | ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

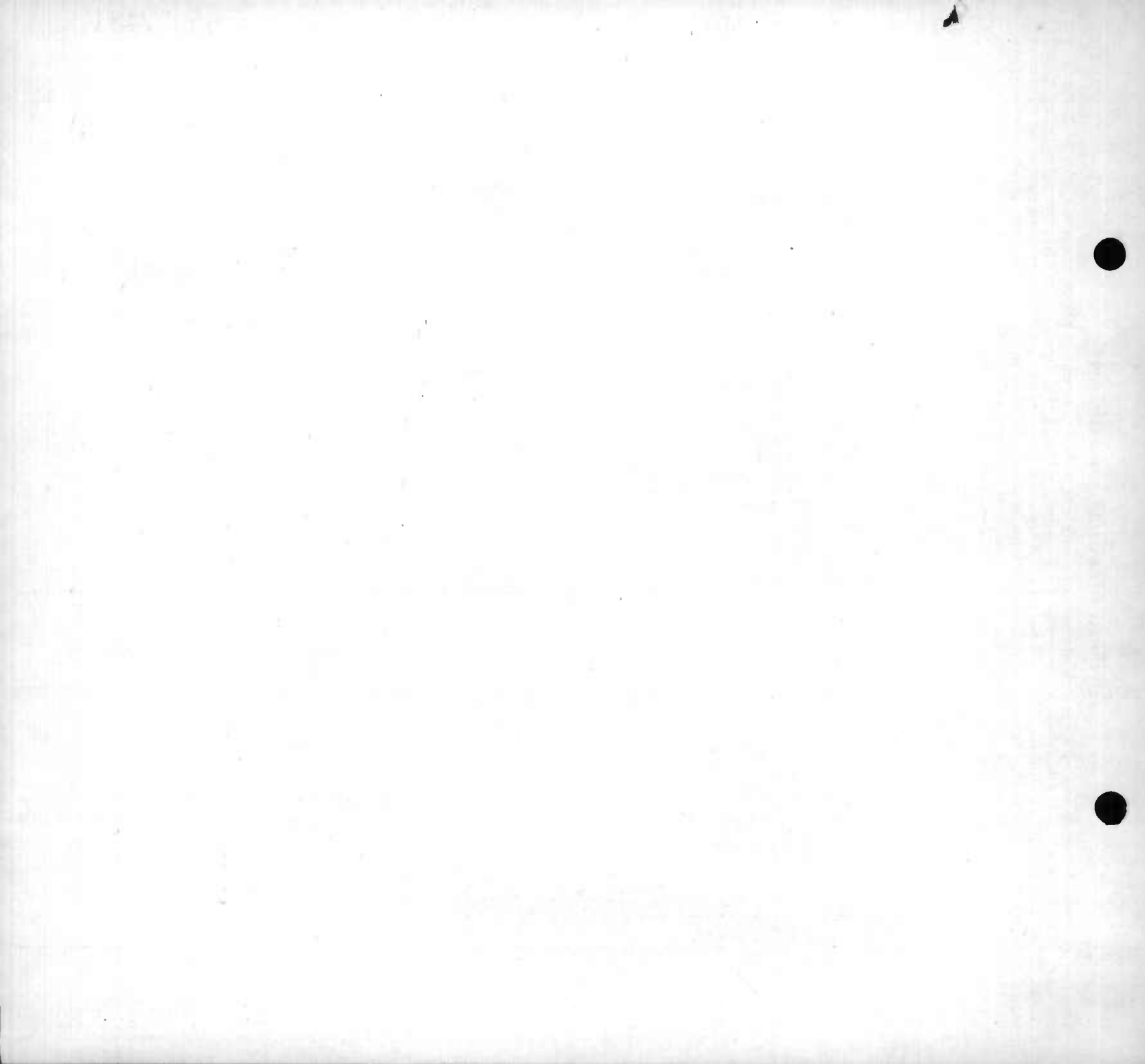
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7483 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7483 | |
|--|-------------------------|---|---|--|-------------------------------|---|--|
| 1. NAME OF DECEASED
(Type or Print) HARRISON P. Smith | | | | 2. DATE AND HOUR OF DEATH
July 15 1965 5:30 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
2023 Frederick Ave. | | (If not in hospital or institution, give street address or location) | | A. STATE
Maryland | | B. COUNTY
2003 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location)
2023 Frederick Ave | | | |
| 5. SEX
MALE | 6. RACE
White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
MARRIED | 8. DATE OF BIRTH
Aug 22, 1894 | 9. AGE (In years last birthday)
71 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MANAGER | | 10B. KIND OF BUSINESS OR INDUSTRY
SUPERMARKET | | 11. BIRTHPLACE (State or foreign country)
Kentucky | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
YES World War I | | 16. SOCIAL SECURITY NO.
406-12-4063 | | 17. INFORMANT
Donald Smith | | ADDRESS
2023 Frederick Ave. | |
| 18. 334X1 | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Arterial Sclerosis | | | |
| ANTECEDENT CAUSES | | | | (B) Hypertension | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Coronary Vascular Disease | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/10-7/15-1965 to 7/15-1965 , that (I) (we) last saw the deceased alive on 7/10-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Charles A. Cahn | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/16-65 | |
| 23C. PHYSICIAN'S NAME (Type)
Charles A. Cahn | | | | 23D. ADDRESS
2145 W. Baltimore St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7-17-65 | | 24C. NAME OF CEMETERY or CREMATORY
MEADOWRIDGE MEMORIAL | | 24D. LOCATION (City, town, or county) (State)
ELK RIDGE, Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
Geo. L. Schwartz
Francis M. Miller | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7484 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7484 | |
|---|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED
(Type or Print) GEORGE AKERS | | | | 2. DATE AND HOUR OF DEATH
7-14-65 12:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
36 FRANKLIN SQUARE HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE
MARYLAND | | B. COUNTY
25-084 | |
| 5. SEX
M | | | | 6. RACE
W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH
8/21/1885 | | 9. AGE (In years last birthday)
79 | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
DANIEL AKER | | | | 14. MOTHER'S MAIDEN NAME
JENNIE BROWNING | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family | | ADDRESS
Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
pulmonary emphysema | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Carcinoma of left lung | | | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-30 19 65 to 7-14 19 65 , that (I) (we) lost saw the deceased alive on 7-14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
HENRY SUMMER | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type)
H. Summer | | | | 23D. ADDRESS
M.D. FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE
7-19-65 | | 24C. NAME of CEMETERY or CREMATORY
Glen Haven Cem | | 24D. LOCATION (City, town, or county) (State)
Colen Burnie Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR
W. C. Kelly, Home 237 | | ADDRESS
237 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

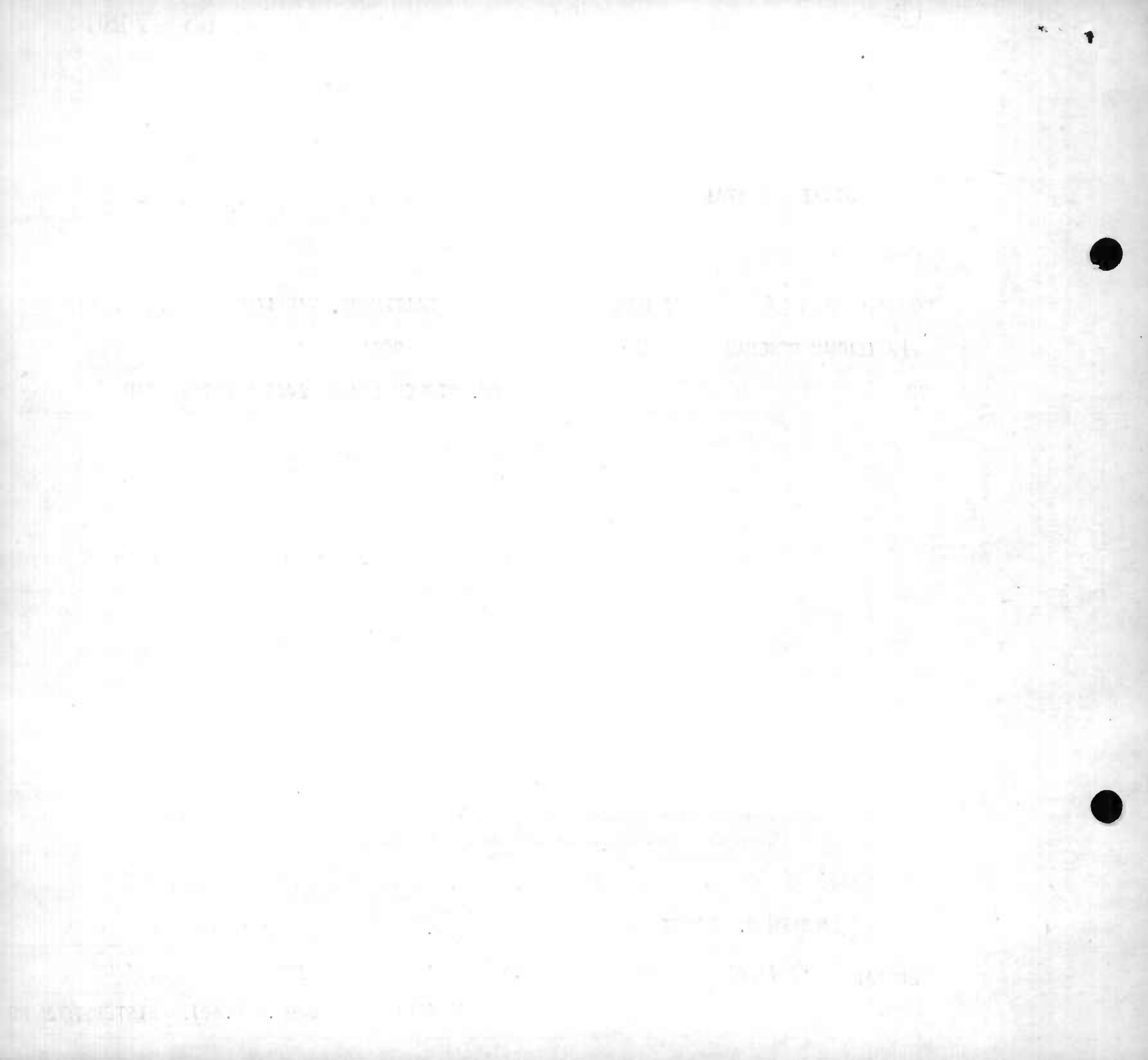
| BIRTH NO. 65 7485 | | BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH | | Registered No. 65 7485 | |
|---|-------------------------|--|---|--|---|
| M.E. CASE NO. MIGADON | | | 2. DATE AND HOUR OF DEATH
7-17-65 1:35 A.M. | | |
| 1. NAME OF DECEASED
(Type or Print) MIGNON FOLB | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
HOSPITAL For the WOMEN OF MD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1111 PARK AVE Apt 316 | | |
| 5. SEX
Female | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH
1895 | 9. AGE (In years last birthday)
70 | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY
NONE (AT Home) | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.N. | | | 13. FATHER'S NAME
ISAAC BLOCK | | |
| 14. MOTHER'S MAIDEN NAME
EMMA BENESCH | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
PATIENTS CHART | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
420.1 I
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
cardiac arrest | | | CAUSE OF DEATH
(A) DUE TO
cardiac arrest | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
Acute myocardial infarction
Arteriosclerotic heart disease | | | (B) DUE TO
Acute myocardial infarction
(C) DUE TO
Arteriosclerotic heart disease | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Obesity | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 3 1965 to July 17 1965 , that (I) (we) last saw the deceased alive on July 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Pacita D. Tan M.D. | | | | 23B. DATE SIGNED
July 17, 1965 | |
| 23C. PHYSICIAN'S NAME (Type)
PACITA D. TAN M.D. | | | | 23D. ADDRESS
Women's Hosp., Baltimore, Md. | |
| 24A. BURIAL CREMATION REMOVAL (Specify)
BURIAL | | 24B. DATE
7/19/65 | | 24C. NAME OF CEMETERY OR CREMATORY
HEBREW FRIENDSHIP | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

1000000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 65 7486 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7486 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED
(Type or Print) LINAS, JENNIE | | 2. DATE AND HOUR OF DEATH
7/15/65 11:50 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
SINAI HOSPITAL of Baltimore, Inc
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE MD. B. COUNTY BALTIMORE CITY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE 21209 | |
| 5. SEX FEMALE | | 6. RACE CAUCASIAN | | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 8. DATE OF BIRTH
3/15/89 | |
| 13. FATHER'S NAME
LEHMAN ROSEMAN | | 14. MOTHER'S MAIDEN NAME
ROSA ? | | 9. AGE (In years lost birthday)
76 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
DR. SIDNEY LINAS 2405 EVERTON ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)
BRAIN METASTASIS | | CAUSE OF DEATH
(A) DUE TO
BRAIN METASTASIS | | INTERVAL BETWEEN ONSET AND DEATH
2 MOS. | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
BONE METASTASIS (widespread) | | (B) DUE TO
BONE METASTASIS (widespread) | | 3 MOS. | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
LEFT VENTRICULAR DECOMPENSATION | | (C) DUE TO
BREAST CARCINOMA | | 5 MOS. | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 5 1965 to JULY 15 1965 , that (I) (we) last saw the deceased alive on JULY 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Joseph S. Weinstock M.D. | | | | 23B. DATE SIGNED
7/16/65 | |
| 23C. PHYSICIAN'S NAME (Type)
JOSEPH S. WEINSTOCK | | | | 23D. ADDRESS
SINAI HOSP, BALTO, INC. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
MIKRO KODESH BETH ISRAEL | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | |
| 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | | 25D. ADDRESS
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |



BIRTH NO. 65 7487

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

2. DATE AND HOUR PRONOUNCED DEAD

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

A. STATE Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

B. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)10B. KIND OF BUSINESS OR INDUSTRY
HENDLER CREAMERY11. BIRTHPLACE (State or foreign country)
WASHINGTON, D. C.12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

EZRA GORDON

14. MOTHER'S MAIDEN NAME

LENA SACKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.
215-03-2811

17. INFORMANT

ADDRESS

MRS. BESSIE GORDON 3527 E FAYETTE ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Calcific aortic stenosis following rheumatic
DUE TO valvulitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/13/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

7/14/65

23C. NAME of CEMETERY or CREMATORY

MIKRO KODESH BETH ISRAEL

23D. LOCATION

(City, town, or county)

BALTIMORE

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUL 19 1965

Robert E. Fisher

SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN

WALL

WALL

WALL

WALL

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WALL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased, was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|------------------|---|------------------|--|---------------------------------|--|--|
| BIRTH NO.
M.E. CASE NO. | | 65 7488 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7488 | |
| 1. NAME OF DECEASED
(Type or Print)
BERTHA WALKER | | | | 2. DATE AND HOUR OF DEATH
July 15, 1965 11:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location)
MT. SINAI NURSING HOME
4613 PARK HEIGHTS AVE | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
MARYLAND
B. COUNTY
BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
641 W FAYETTE ST | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
WIDOWED | 8. DATE OF BIRTH | 9. AGE (In years last birthday)
75 | If Under 1 Yr.
Months: Days: | If Under 24 Hrs.
Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY
AT HOME | | 11. BIRTHPLACE (State or foreign country)
AUSTRIA | | 12. CITIZEN OF WHAT COUNTRY?
U SA | |
| 13. FATHER'S NAME
ABRAHAM RICHTER | | | | 14. MOTHER'S MAIDEN NAME
LEAH ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MR. ALVIN RICHTER 5225 COLLINS AVE BEACH, FLA | | | |
| 18. 332X1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Cerebral Thrombosis
DUE TO
(B) Cerebral arteriosclerosis
DUE TO
(C) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 days
Several years
Several years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 19 65 to July 15 19 65, that (I) (we) last saw the deceased alive on July 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Seymour H. Rubin | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
7/15/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Seymour H. Rubin | | | | 23D. ADDRESS
5415 Park Heights Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7/16/65 | | 24C. NAME OF CEMETERY or CREMATORY
ADATH JESHURUN (SODOVA) | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Taylor | | 25C. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | ADDRESS
6010 REISTERSTOWN RD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 7489 |
|---|---------|--|------------------|--|
| BIRTH NO. 65 7489 | | | | CERTIFICATE OF DEATH |
| M.E. CASE NO. | | | | Registered No. |
| 1. NAME OF DECEASED
(Type or Print) | | 2. DATE AND HOUR OF DEATH | | |
| FRANCIS F. BEICHLER (CHARLES F.) | | 7-15-65 6.45 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | |
| Church Home and Hospital | | Maryland 26-02 | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | Baltimore 6 | | |
| | | D. STREET ADDRESS (If rural, give location) | | |
| | | 4811 Pleasant View Ave | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) |
| Male | White | Single | 9-30-33 | 31 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) |
| Dragon Bell Tel. | | Telephone industry Maryland | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? |
| Frederick H. BEICHLER | | Lillian Jares | | USA |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| YES | | | | Mr. & Mrs. Frederick Beichler - 4811 Pleasant View Ave |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ACUTE MONOCYTTIC LEUKEMIA | | (A) DUE TO | | months |
| ANTECEDENT CAUSES | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-13-1965 to 7-15-1965, that (I) (we) last saw the deceased alive on 7-15-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED |
| Jose S. Maysos | | | | 7-15-65 |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | |
| Jose S. Maysos | | Church Home & Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY |
| BURIAL | | 7-19-65 | | HOLY REDEEMER CEM. |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS |
| JUL 19 1965 | | Robert E. Taylor | | Harley Kille - 2334 Jefferson St. |

2019-2020 2020-2021

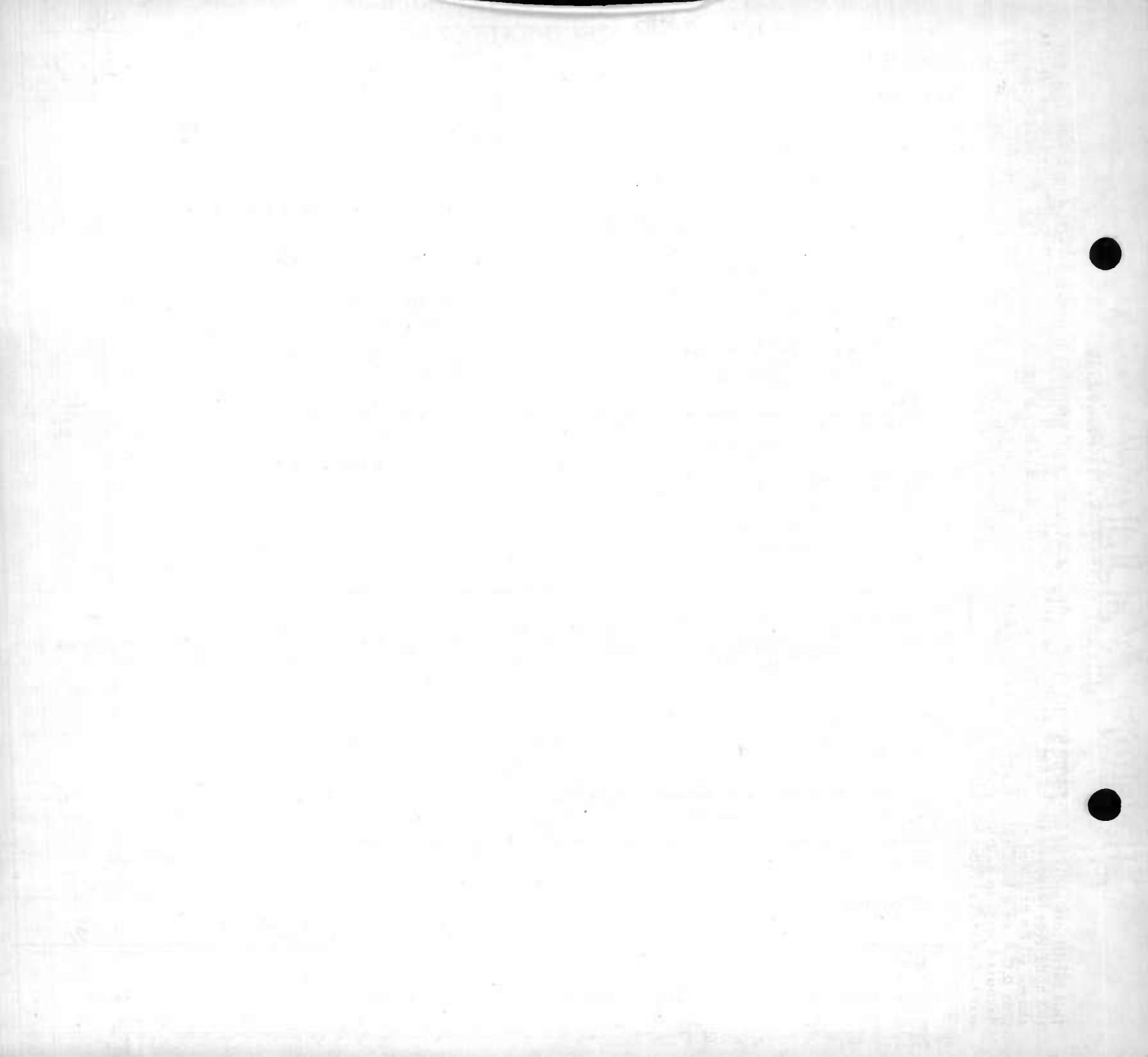
2-1-7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|----------------------|---|--|---|---|
| BIRTH NO.
65 7490 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7490 | |
| M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print)
JOSEPH E. HEIM | | 2. DATE AND HOUR OF DEATH
7-15-65 6:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
402 N. MADIERA ST. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY
MARYLAND 6-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
402 N. MADIERA ST. | | | |
| 5. SEX
M | 6. RACE
W | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
DIVORCED | 8. DATE OF BIRTH
9-13-1916 | 9. AGE (In years last birthday)
48 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY
BREWERY | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
HARRY HEIM. | | 14. MOTHER'S MAIDEN NAME
ANNA BROOKS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
No. | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
Mrs. Myrtle Kaptan - 402 N. Madiera St. | | |
| 18. 491X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) DUE TO
Pneumonia
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
3d | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
II
Herd (Heavy drunk) | | 19A. DATE OF OPERATION
0 | | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
suicidal gm | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 60 to 15 Jul 19 65, that (I) (we) last saw the deceased alive on 15 Jul 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
J. HULLA | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
16 Jul 65 | |
| 23C. PHYSICIAN'S NAME (Type)
J. HULLA | | 23D. ADDRESS
2214 E Fayette St 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | 24B. DATE
7-19-65 | 24C. NAME of CEMETERY or CREMATORY
BALTIMORE Cem. | | 24D. LOCATION (City, town, or county) (State)
BALTO., Md | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
Robert E. Fairbank | | 25C. FUNERAL DIRECTOR
Hartley - 2334 Jefferson St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 7491 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7491 | |
|--|-------------------------|--|-----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED
(Type or Print) John Dimirkow | | | | 2. DATE AND HOUR OF DEATH
7-17-65 3:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Church Home + Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY 1-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
7222 E. Lombard St. | | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
3-2-24 | 9. AGE (In years last birthday)
41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Baker | | 10B. KIND OF BUSINESS OR INDUSTRY
Bakery | | 11. BIRTHPLACE (State or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
Russian FIRST PAPERS | |
| 13. FATHER'S NAME
Alexander Dimirkow | | | | 14. MOTHER'S MAIDEN NAME
Maria P UNK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
114-26-0249 | | 17. INFORMANT
MARIA DIMIRKOW | | ADDRESS
2222 E. LOMBARD ST 31 | |
| 18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH
(A) Acute Myocardial infarction
DUE TO
(B) _____
DUE TO
(C) _____ | | INTERVAL BETWEEN ONSET AND DEATH
8 days | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION
7-9-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-9-65 to 7-17-65 , that (I) (we) first saw the deceased alive on 7-17-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
Jose S. Maisog M.D. | | | | 23B. DATE SIGNED
7-17-65 | | 23C. PHYSICIAN'S NAME (Type)
Jose S. Maisog M.D. | |
| 23D. ADDRESS
Church Home and Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | | | | |
| 24B. DATE
7/20/65 | | 24C. NAME of CEMETERY or CREMATORY
ST. ANDREWS CEMETERY | | 24D. LOCATION (City, town, or county) (State)
GERMAN HILL RD. BALTO. | | 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | |
| 25B. NAME OF REGISTRAR
Robert E. Farley | | 25C. FUNERAL DIRECTOR
THE DIPPEL BROTHERS INC. 1800 E. LOMBARD ST. 21231 | | | | | |

2522 S. Thompson St

3-2-24 W

Room

Room 2

Room 2

Room 2

Room 2

Room 2

1-2-24 W 1-11

1-11-24
Check Room and Room 2

1-11-24
Room 2
Room 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

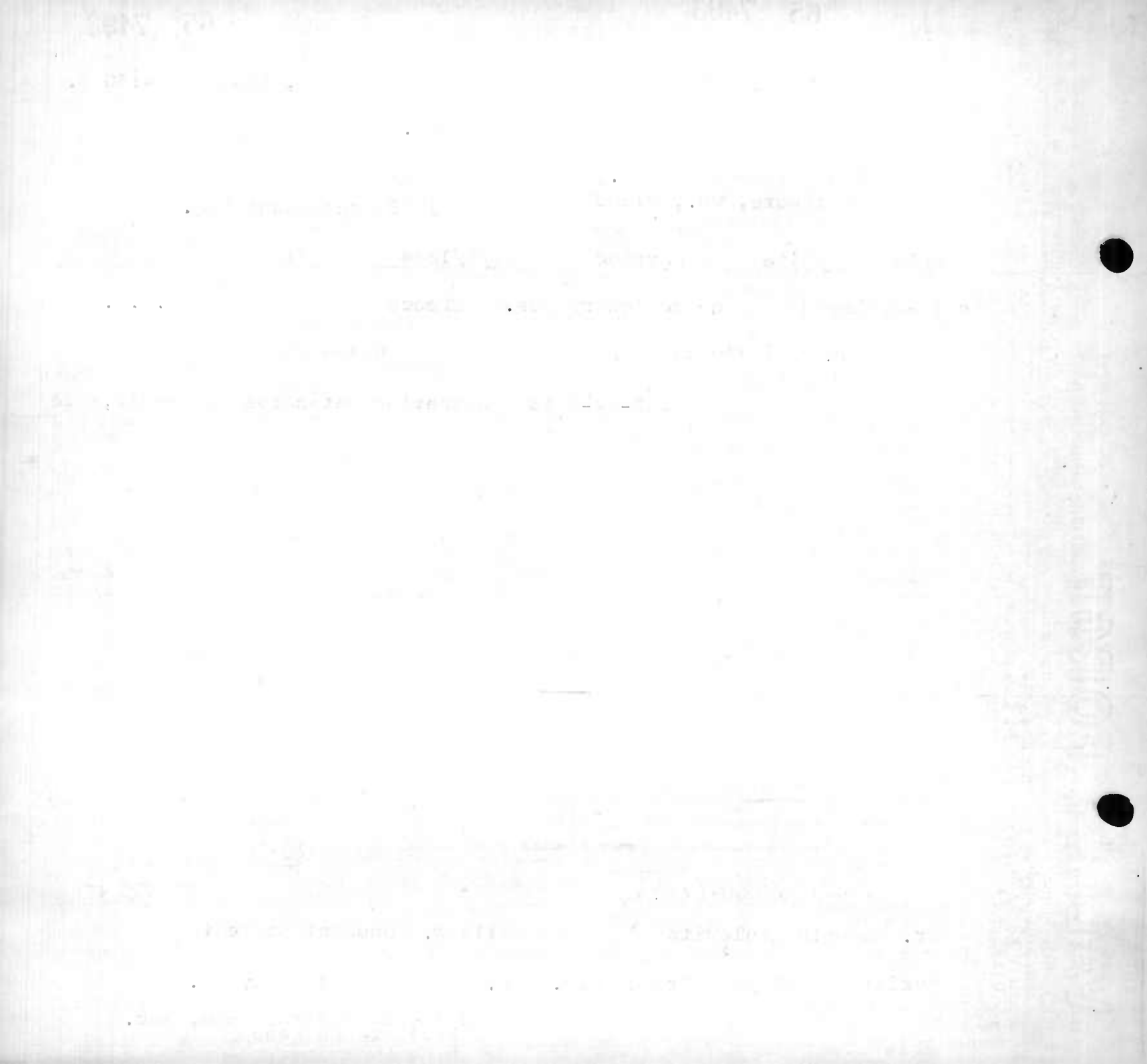
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---|--------------|---|--|---|---------------------------------------|---|--|---|----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 65 7492 | |
| BIRTH NO.
65 7492 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) Evelyn Kloor | | | | | | 2. DATE AND HOUR OF DEATH
13 July 65 9:50 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Montebello State Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3512 Rolling Rd. | | | | | |
| 5. SEX
F | 6. RACE
W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
married | | 8. DATE OF BIRTH
3/10/17 | 9. AGE (In years lost birthday)
48 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
George D. Edmondson | | | | | | 14. MOTHER'S MAIDEN NAME
Bernice Cingman | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
213-38-5826 | | 17. INFORMANT
Clarence Kloor | | ADDRESS
3512 Rolling Rd. | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
199.2 I | | | | | | (A) cardiac failure
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (B) inanition
DUE TO | | | | | |
| | | | | | | (C) carcinomatosis | | | 2 yrs | | |
| II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION
2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No)
Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/27 1965 to 7/13 1965, that (I) (we) last saw the deceased alive on 7/13 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE
Robert W. Ireland M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/13/65 | |
| 23C. PHYSICIAN'S NAME (Type)
Robert W. Ireland M.D. | | | | | | | | 23D. ADDRESS
Montebello State Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7-16-65 | | 24C. NAME OF CEMETERY or CREMATORY
Woodlawn Cemetery | | | | 24D. LOCATION (City, town, or county) (State)
Woodlawn Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | | 25B. NAME OF REGISTRAR
Robert E. Taylor, M.D. | | | | 25C. FUNERAL DIRECTOR
Spring Byers Funeral Home | | | |
| ADDRESS
8728 Liberty Rd. Randallstown Md. | | | | | | | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 7493 | |
|---|-------------------------|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 7493</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED
(Type or Print) JAMES MILLIONIE</p> </div> <div> <p>2. DATE AND HOUR OF DEATH
July 13, 1965 4:50 p. M.</p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1003 Greenmount Ave., Baltimore, Md., 21202</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Md. B. COUNTY 10-01</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore</p> <p>D. STREET ADDRESS (If rural, give location)
1003 Greenmount Ave.</p> | | |
| 5. SEX
male | 6. RACE
white | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married | 8. DATE OF BIRTH
1/1/1884 | 9. AGE (In years last birthday)
81 | <p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
self-employed</p> | | | <p>10B. KIND OF BUSINESS OR INDUSTRY
Confectionery Bus.</p> | | <p>11. BIRTHPLACE (State or foreign country)
Greece</p> |
| <p>12. CITIZEN OF WHAT COUNTRY?
U.S.A.</p> | | | <p>13. FATHER'S NAME
Thomas Millionie</p> | | |
| <p>14. MOTHER'S MAIDEN NAME
unknown</p> | | | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
217-32-8116</p> | | |
| <p>16. SOCIAL SECURITY NO.
217-32-8116</p> | | | <p>17. INFORMANT ADDRESS above
Katherine Antonatos Millionie, wife</p> | | |
| <p>18. 422.1 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>INTERVAL BETWEEN ONSET AND DEATH
5 yrs.</p> <p>ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) congestive heart failure
DUE TO arteriosclerotic C-V Disease
10 yrs.</p> <p>(B) anasarca
DUE TO arteriosclerotic C-V Dis.
2 wks.</p> <p>(C) pericarditis
10 yrs.</p> <p>II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| <p>19A. DATE OF OPERATION
0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)
NO</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from 7/12/1965 to 7/13/1965 that (I) (was) last saw the deceased alive on 7/12/1965 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (do not) view the body after death. (K.K.)</p> | | | | | |
| <p>23A. SIGNATURE
Kenneth Krulevitz</p> | | | | <p>23B. DATE SIGNED
7/15/65</p> | |
| <p>23C. PHYSICIAN'S NAME (Type)
Dr. Kenneth Krulevitz</p> | | | | <p>23D. ADDRESS
115 W. Monument Street</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)
Burial</p> | | <p>24B. DATE
7/17/65</p> | | <p>24C. NAME of CEMETERY or CREMATORY
Greek Orth. Cem.</p> | |
| <p>24D. LOCATION (City, town, or county)
Baltimore, Md.</p> | | <p>24E. STATE (State)
Md.</p> | | | |
| <p>25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965</p> | | <p>25B. NAME OF REGISTRAR
Robert E. J. J.</p> | | <p>25C. FUNERAL DIRECTOR ADDRESS
Schimunek Funeral Home, Inc. 3331 Brehms Lane</p> | |



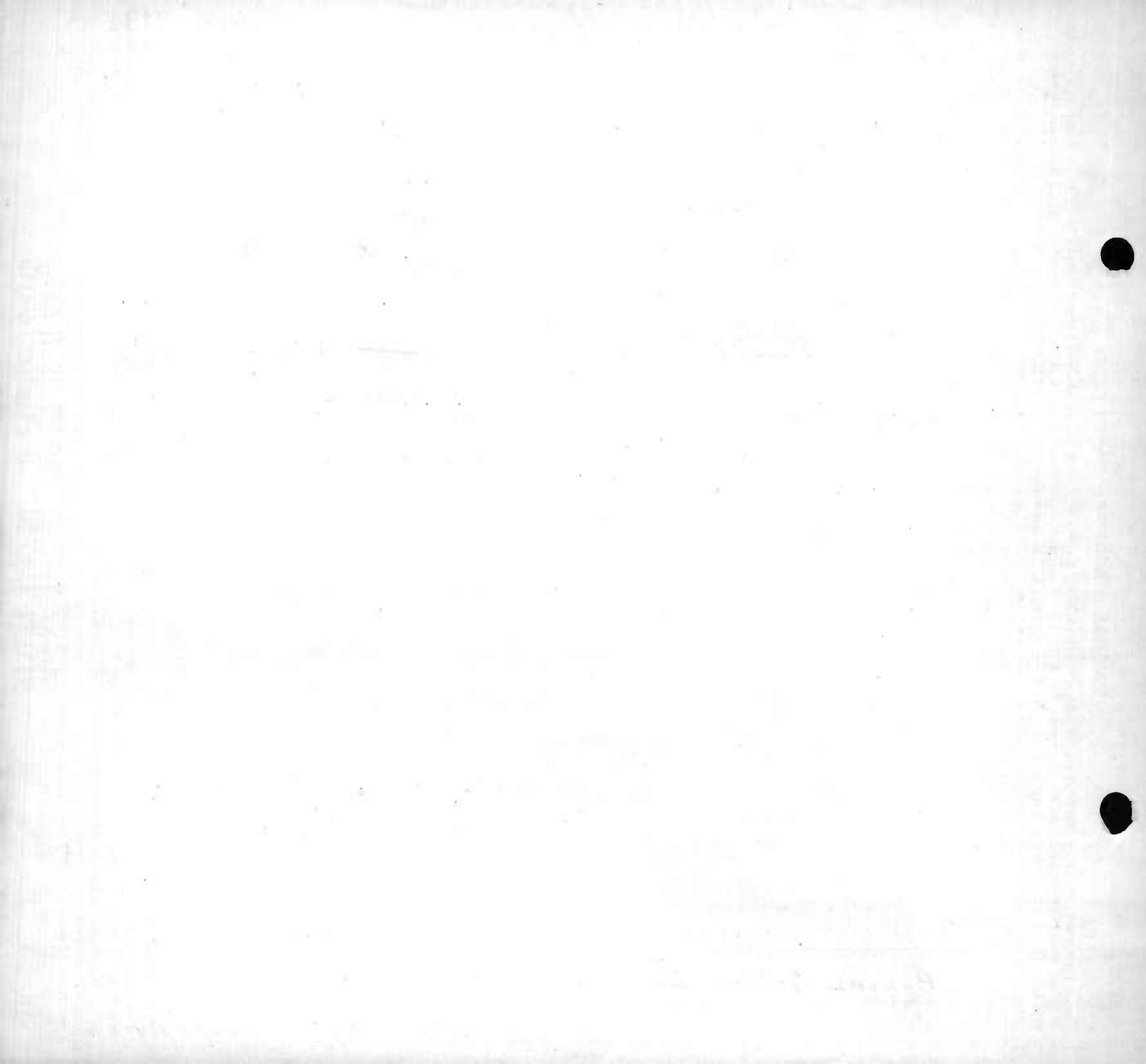
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|------------------------------------|--|---|
| BIRTH NO.
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) | | BALTIMORE CITY DEPARTMENT
65 7494
CERTIFICATE OF DEATH | | Registered No. 65 7494 | |
| Dolly Brown | | 2. DATE AND HOUR OF DEATH
July 17, 1965 7:30 a.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION
If not in hospital or institution, give street address or location | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE
B. COUNTY
Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
412 Cumming Court | | | |
| 5. SEX
Female | 6. RACE
Negro | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed | 8. DATE OF BIRTH
April 22, 1914 | 9. AGE (In years lost birthday)
51 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 10B. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (State or foreign country)
South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Ansley Wilks
unknown | | | |
| 14. MOTHER'S MAIDEN NAME
unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. B.J. Brown-daughter | | ADDRESS
same | |
| 18. 593X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH
(A) Chronic renal failure
DUE TO
(B) DUE TO
(C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)
<input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 3, 1965 to July 17, 1965, that (I) (we) last saw the deceased alive on July 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
A. Rigaud | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
July 17, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS
1514 Division Street Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
7-22-65 | | 24C. NAME OF CEMETERY or CREMATORY
10th Pilgrim Church Cem. | |
| 24D. LOCATION
S.C. | | 24E. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | | |
| 24F. NAME OF REGISTRAR
E. Taylor | | 24G. FUNERAL DIRECTOR
MORTON S. Dye | | | |
| 24H. ADDRESS
1701 Laurens St. | | | | | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH MACK

2. DATE AND HOUR PRONOUNCED DEAD

7/17/65 11:56 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1100 Brewer St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

10-23-23

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Beth Steel

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Charlton, W. VA

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

LENA MACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean

16. SOCIAL
SECURITY NO.

216-16-3210

17. INFORMANT

ADDRESS

LENA M. Johnson 1102 Brewer ST.

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) Multiple injuries
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Baltimore - Washington Expressway 53-00

21D. TIME
OF INJURY
(APPROX.)

7 17 65 4:07 a. m.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

struck by automobile

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/17/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

7-21-65

23C. NAME OF CEMETERY or CREMATORY

BA/40. NAT'L

23D. LOCATION

(City, town, or county)

A.A. Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUL 19 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Morton L. Dyett

ADDRESS

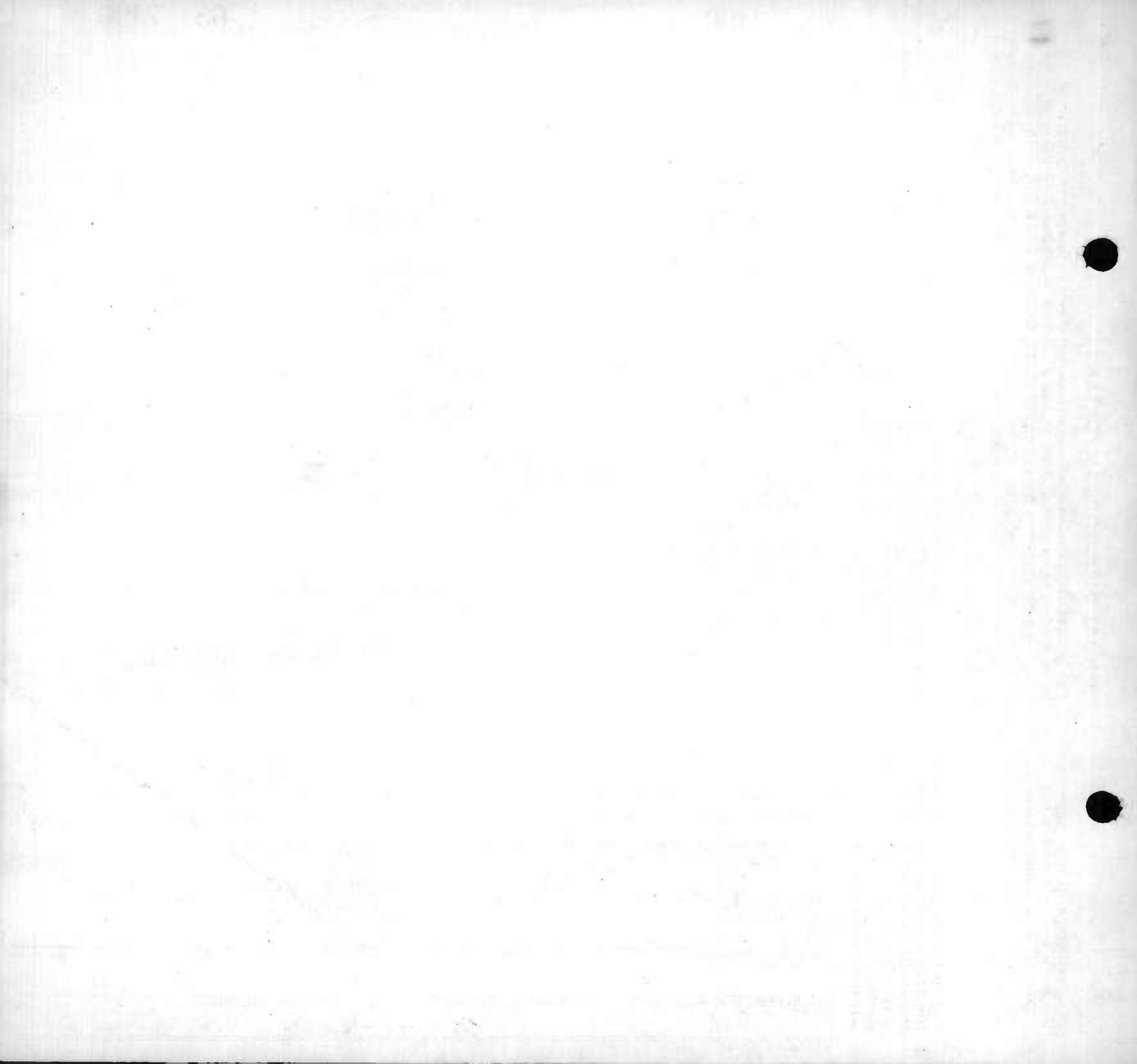
1701 Laurens St.

North of Harbor Tunnel
Thru-way.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-----------|--|------------------|--|---|
| BIRTH NO. 65 7496 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7496 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH 7-17-65 1355 P.M. | |
| 1. NAME OF DECEASED (Type or Print) CLARA Gorrell. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Memorial Nursing Home. 27 N. Carey Street. Baltimore, Maryland 21223 | | A. STATE B. COUNTY MARYLAND. 17-02 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore. | | D. STREET ADDRESS (If rural, give location) 1126 Argyle | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) 64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balt. Md. | |
| 13. FATHER'S NAME unk | | 14. MOTHER'S MAIDEN NAME unk | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Lincoln Nursing Home 27 N. Carey St | |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Cardio Vascular Real Disease (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH ? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 29 1964 to July 17 1965 that (I) (we) last saw the deceased alive on July 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M.D. Attending Phys. [Signature] | | 23B. DATE SIGNED 7-17-65 | | 23C. PHYSICIAN'S NAME (Print) M.D. [Signature] | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE JUL 19 1965 | | 24C. NAME of CEMETERY or CREMATORY W. Calvary | |
| 24D. LOCATION (City, town, or county) (State) A.A. County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Address Morten + Dyett 1701 Lawrence St | | | |



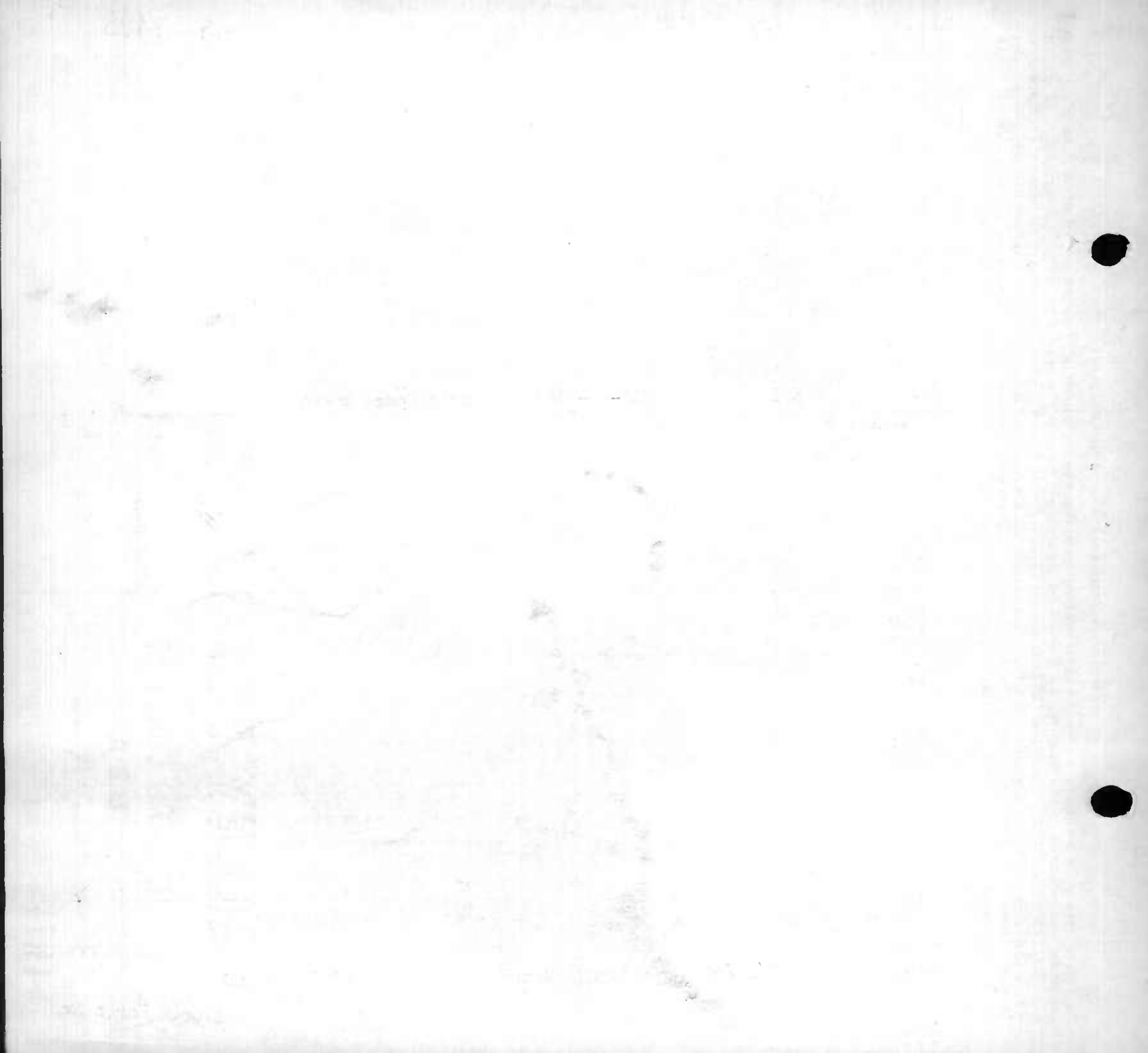
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|--|--|---|
| BIRTH NO. 65 7497 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 7497 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED
(Type or Print) Tate, James | | | 2. DATE AND HOUR OF DEATH
July 17, 1965 12:30 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 25-33 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
UNIV. HOSP | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| (If not in hospital or institution, give street address or location) | | | D. STREET ADDRESS (If rural, give location)
2511 Ridgely St. 30 | | |
| 5. SEX
M | 6. RACE
N | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH
2/7/98 | 9. AGE (In years last birthday)
67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Wash. D.C. | |
| 13. FATHER'S NAME
John Tate | | | 14. MOTHER'S MAIDEN NAME
Ellie Ford | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-03 0366 | | 17. INFORMANT
Mary Robinson 2511 Ridgely St. | |
| 18. 332X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH
(A) Cerebral Thrombosis
DUE TO
(B) Atherosclerosis
DUE TO
(C) | | INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION
2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No)
YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/16 1965 to 7/17 1965, that (I) (we) last saw the deceased alive on 7/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE
Franklin M. Preiser | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED
7/17/65 |
| 23C. PHYSICIAN'S NAME (Type)
Franklin M. Preiser | | | 23D. ADDRESS
University Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
7/21/65 | | 24C. NAME OF CEMETERY or CREMATORY
Mt. Auburn Cem | |
| 24D. LOCATION (City, town, or county)
Balt. Md. | | 24E. STATE
Md. | | 24F. ADDRESS
A. Holstad 918 Druid Hill Ave. | |
| 25A. DATE REC'D BY HEALTH DEPT.
JUL 19 1965 | | 25B. NAME OF REGISTRAR
J. J. J. | | 25C. FUNERAL DIRECTOR
A. Holstad | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

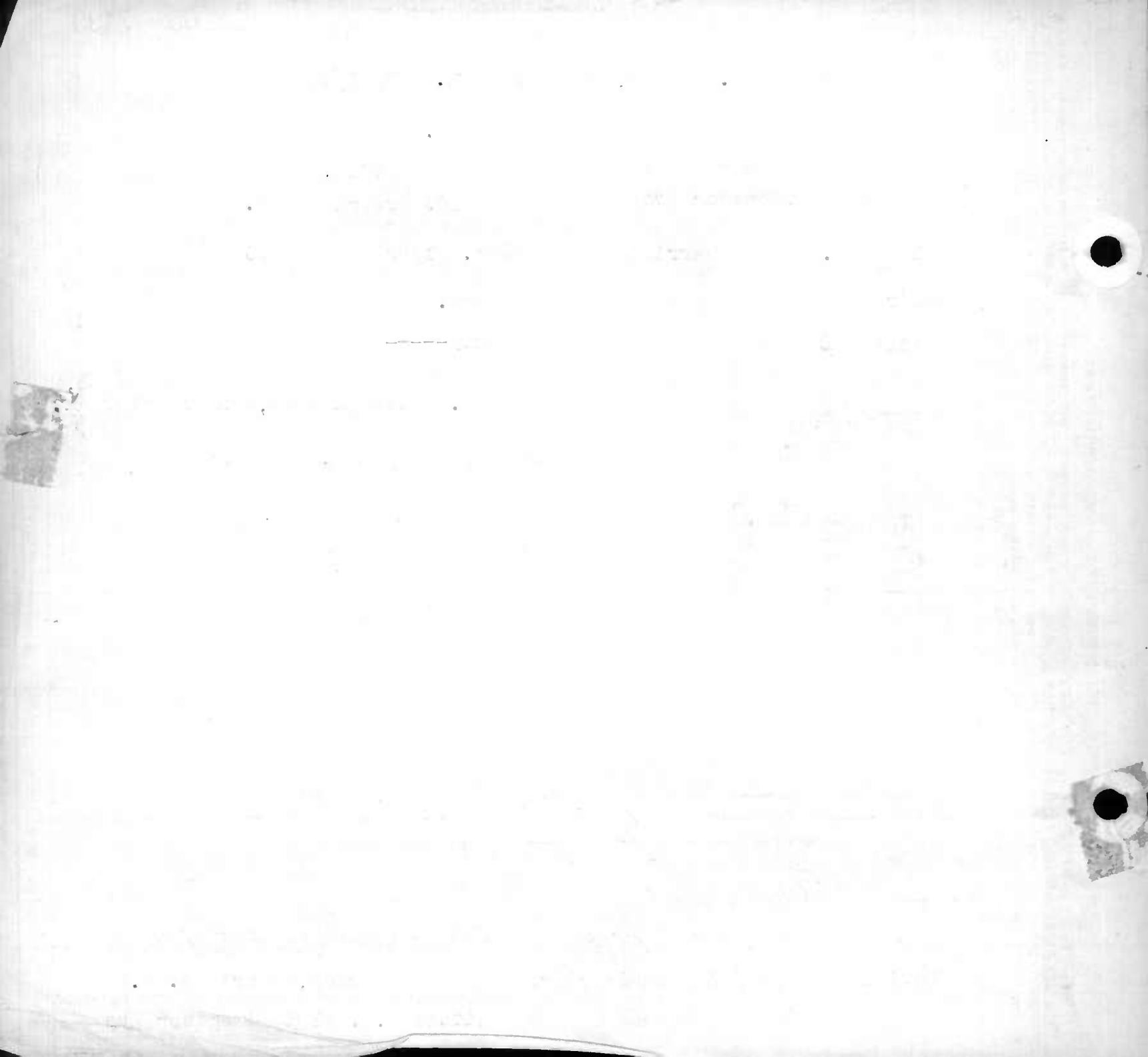
| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---------------------------------|--|----------------------------|--|--|--|---------|--|--|--|--|--|
| BIRTH NO.
M.E. CASE NO. | | | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. | | | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | | | | 2. DATE AND HOUR OF DEATH | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY | | | | | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
(If not in hospital or institution, give street address or location) | | | | | | C. CITY OR TOWN
(If outside city limits, write RURAL and give township) | | | | | | D. STREET ADDRESS
(If rural, give location) | | | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | ADDRESS | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | CAUSE OF DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work Not While At Work | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from that (I) first saw the deceased alive on and hour and from the causes stated above. (I) (We) (did) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | | | | | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | 23D. ADDRESS | | | | | | | | | | | | | |
| 24A. DATE REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | | | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| BIRTH NO. 8 65 7499 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 7499 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Francisco C. Bloomer, also Frank C. | | | |
| 2. DATE AND HOUR OF DEATH 7/17/65 | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hoods Nursing Home 5313 Edmondson Ave | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | | |
| 5. SEX Male | | | | 6. RACE W. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH Jan. 31/89 | | | | 9. AGE (in years last birthday) 76 | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Mass. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Nelson Bloomer | | | |
| 14. MOTHER'S MAIDEN NAME Lucy | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mrs. Emily Bloomer, 309 Greenlow Rd. ADDRESS Catonsville 28, M | | | |
| 18. 153.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) CARCINOMA SIGMOID & METASTASIS LIVER (B) ARTERIO-SCLEROTIC CHANGE VASCULAR DISEASE (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 7/17 to 7/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | 23A. SIGNATURE John D. Shaw M.D. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED 7/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) John D. Shaw M.D. | | 23D. ADDRESS 5800 Edmondson Ave. Catonsville 28, MD | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7/20/65 | |
| 24C. NAME OF CEMETERY or CREMATORY Meadowridge | | 24D. LOCATION Dorsey, Howard Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. JUL 19 1965 | | 25B. NAME OF REGISTRAR R. E. F. Adams | |
| 25C. FUNERAL DIRECTOR Witzke F.D. | | 25D. ADDRESS 4101 Edmondson Ave | | VS 150-REV. 1/1/65 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|--|-----------|--|----------------|--|
| BIRTH NO. | | 4 65 7500 | | 65 7500 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED
(Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Gertrude K. Noppenberger | | | 7/17/65 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 1403 Cliftview Ave. | | | Md. 8-05 | | |
| 5. SEX | | | 6. RACE | | |
| Female | | | White | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH | | |
| Widow | | | Aug. 22/79 | | |
| 9. AGE (In years last birthday) | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | |
| 85 | | | H.W. | | |
| 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Md. | | | USA | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Patrick Scally | | | Annie Cummings | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| | | | | | |
| 17. INFORMANT | | | ADDRESS | | |
| Miss Anna Noppenberger | | | 1403 Cliftview Ave | | |
| 18. 4 22. 11 | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) Congestive heart failure | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | DUE TO | | |
| ANTECEDENT CAUSES | | | Arteriosclerotic cardio-vascular disease | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| | | | (C) | | |
| II | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 2 mrs. | | |
| 19A. DATE OF OPERATION | | | 20A. AUTOPSY? (Yes or No) | | |
| | | | No | | |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED | | |
| | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 19 59 to June 17, 19 65, and that (I) (we) last saw the deceased alive on June 17, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| E. Paul Coffay Jr. | | | 7/19/65 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| E. Paul Coffay Jr., M.D. | | | 3100 St. Paul Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | |
| Burial | | | 7/20/65 | | |
| 24C. NAME of CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | |
| Holy Redeemer | | | Baltimore Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | |
| JUL 19 1965 | | | Robert E. Farley, M.D. | | |
| 25C. FUNERAL DIRECTOR | | | ADDRESS | | |
| Witzke F.D. | | | 4101 14th Avenue | | |

